Project RECONNECT

(Responsibilities, Education, Competency, Opportunities, Networking, Employment, and Collaboration for Transition)

Program Manual

Utah Department of Human Services
Division of Substance Abuse and Mental Health

SAMHSA

State of Utah

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February 2009

Transitioning from adolescence into adulthood is not easy. Events like finishing high school, finding a job or pursuing higher education, and living independently can be stressful. This transitional phase can be especially challenging for young people living with mental health issues.

In 2002, Utah Division of Substance Abuse and Mental Health (DSAMH) was pleased to receive funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to plan, implement and sustain the Partnerships for Youth Transition (PYT) program.

A new project emerged in Utah that would assist youth with serious emotional disturbances or emerging mental illnesses (between the ages of 14 and 25) to successfully transition from childhood to adulthood. **Project RECONNECT** (Responsibilities, Education, Competency, Opportunities, Networking, Neighborhood, Employment, and Collaboration for Transition) was established and has served young people in twelve counties in the State of Utah.

Implementing this important program for youth in transition has been a great learning experience for DSAMH. This Program Manual demonstrates how Utah implemented the program and shares some of the lessons learned. We hope that through this Program Manual, other states can engage in this important initiative and facilitate in helping young people reach their full potential.

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I. Introduction to the Manual

A. Utah's Transitional Services

In 2002, the Utah State Division of Substance Abuse and Mental Health (DSAMH) was awarded a federal grant from the United States Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), Bureau of Child and Adolescent Mental Health. The funding ($500,000 each year from October 2002 to September 2006) provided the State of Utah with an opportunity to systematically plan, implement and sustain transitional services within the public mental health system to assist young people with serious emotional disturbances or emerging mental illness between the ages of 14 and 21. Utah's project was named **Project RECONNECT** (Responsibilities, Education, Competency, Opportunities, Networking, Neighborhood, Employment, and Collaboration for Transition). There were four community mental health centers that participated in the project, covering seven counties - two rural and five urban.

Within the four years of operation, Project RECONNECT produced positive outcomes at different levels:

1. **System Change**: Project RECONNECT enabled the Division to enhance the Utah public mental health system in areas of practices, collaboration, funding, data infrastructure, family and youth development, and cultural competency.

    a. Practice: Prior to Project RECONNECT, implementation of evidence-based practices (EBPs) was limited to staff training on various practice models. Project RECONNECT provided training in the Transitions to Independence Process (TIP) system to staff. The intent was this system would address the issue of fidelity through providing on-going training, monitoring and supervision.

    b. Collaboration: Project RECONNECT strengthened inter-agency collaboration by encouraging mental health centers to work with agencies from education, employment, housing, juvenile justice, and child welfare with the overall intent to improve youth transition services. The intra-agency collaboration focused on improving coordination between children's services and the adult system so that transitional services are less fragmented.

    c. Funding: Prior to Project RECONNECT, Utah's community mental health centers relied heavily on Medicaid for funding. Project RECONNECT funded services for mental health centers to increase their capacities to serve young people without Medicaid. Through collaboration with the mental health center, child welfare, and juvenile justice, an improved system to serve youth emerged. These efforts facilitated various levels of service provisions to young people outside the traditional mental health population.

    d. Data infrastructure: Prior to Project RECONNECT, community mental health centers collected data and submitted to DSAMH for reporting purposes. Project RECONNECT implement and used a new web-based data collection system to collect and analyze program and client data. This automated analysis allowed administrative and clinical staff to use the data to make important decisions.

e. Family and youth development: Project RECONNECT established Family Councils and Youth Action Councils at local and state levels. The resulted in systematic changes to better assist families and youth. A curriculum was developed to assist families in effectively helping their children transition into adulthood. The Youth Action Councils provided opportunities for youth to develop leadership qualities and bring their ideas about needs for successful transition.

f. Cultural competency: Project RECONNECT developed a Cultural Competency Practice Model to guide service delivery for people with cultural and linguistic diversities. Prior to Project RECONNECT this area did not received adequate attention.

2. **Direct Services:** At the end of the project, 275 youth/young adults received services. Out of the 275 project participants, 68% are Caucasian, 8.4% Hispanic, 3.6% African-American, 3.6% Native American, and 1.1% Asian. Additionally, approximately 58% have special characteristics: 4.73% youth as parents, 7.64% homeless, 10.18% racial/ethnic minorities, 3.64% with physical disabilities, and 19.64% youth in state custody. The project enrolled 41.5% young women and 54.9% young men.

B. Description of the Manual

The target audience of this manual is administrators, managers, clinicians, transitional facilitators, case managers, families and young people. The manual is written to assist them examining the feasibility of implementing the TIP model with fidelity. The manual addresses three components: administrative, systemic, and clinical.

The administrative component speaks to issues that affect the organizational administration of the project such as eligibility and admission criteria, collaboration, management structure and staffing pattern, and program costs.

The system component addresses issues that affect the systematic delivery of services such as intra-agency collaboration, youth development, and cultural competency.

The clinical component deals with the issues that affect the direct service delivery – these include: pathway into care, screening, assessment, treatment planning, and transitional facilitation.

The Utah Division of Substance Abuse and Mental Health hopes this manual will provide the key stakeholders with information to implement the project model with fidelity:

1. **Administrators and managers**: This manual will provide a blue print for people in the administrative and management positions to develop a service system that effectively assists young people with serious emotional disturbances or emerging mental illness to transition into adulthood. Such a service system will address issues of practices, collaboration, funding, data infrastructure, family and youth development, and cultural competency. A fidelity checklist (included in this manual) will assist administrators and managers to ensure fidelity of the system developed and services implemented.
2. **Clinicians, transitional facilitators, and case managers**: The manual will assist in demonstrating how to implement the service model and develop interagency and intra-

agency collaboration. The fidelity checklist (included in this manual) will assist in helping to self monitor the fidelity issue.

3. **Families and young people**: The manual assists families and young people to know what they should expect from transitional services. They will be able to monitor services provided to them, and have the ability to become better advocates of the services they are receiving. They will know if identified services listed in the manual are not being provided or if the system where they are receiving service is not responsive to the needs of the families and youth.

C. Description of Planning Process

Project RECONNECT determined it was important find out from all involved in the project what was their perception about the "needs" were in a system to support successful transitional services. The decision was made to establish two focus groups wherein the information could be obtained. One of the focus groups would be comprised community partners, families and young people and conducted by a Family Advocate to ensure that focus group members felt free to express their points of view. The other focus group would be comprised of administrators, supervisor, transitional facilitators, and case managers; and the Project Director would conduct this group. Each focus group would address standard questions, and their responses were compared to detect differences of opinions. Some of the focus group questions included:

1. What should transitional services include? If possible, rank the order of importance.
2. What should be the role of _____ (choose from state, administrator, supervisor, transitional facilitators, case manager, family and young people) in transitional services for youth ages 14-21 with emotional disorders or emerging mental illness? Please elaborate in the category that fit your role but also briefly discuss the others.
3. What roles mentioned in the previous question are not being appropriately performed by those groups?
4. What are the major strengths of the transitional services available in your area?
5. What are the limitations of the transitional services available in your area? What should be improved?
6. What should young people who successfully graduate from transitional services know, understand, and be able to do?
7. Do you feel that the existing transitional services are preparing the program participants with such knowledge, awareness, and skills?
8. Is there anything else you would like to tell us about?

II. Introduction of the Practice

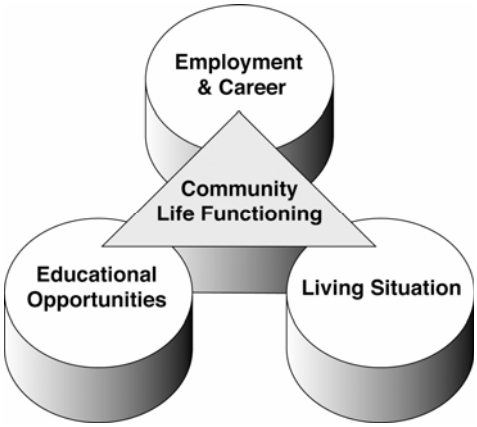
A. Theoretical Framework of the Practice

Project RECONNECT's intervention model is based on the Transition to Independence Process (TIP) system developed by Hewitt B. "Rusty" Clark, Ph.D. and his colleagues at the University of South Florida (Clark, H.B., 2004, Revised). TIP is guided by the principles of the System of Care and Wraparound Services, with specific attention to skills development and competency

attainment in four transitional domains: education, employment, living situation, and community life adjustment. The model has a strong youth development and family involvement focus. Project RECONNECT adapted the TIP guidelines to develop the project guiding principles:

1. Person-centered planning is driven by the young person's interests, strengths, and cultural and familial values.
2. Community inclusion environment will assist the young person to function in the whole community and in the least restrictive setting.
3. Services and support must be individually tailored and comprehensively designed to encompass all transitional domains.
4. Services and support need to be coordinated to provide continuity from the young person's perspectives.
5. A safety net of support expresses hopefulness and guarantees commitment by staff, other service providers, and support systems.
6. The young person needs to acquire relevant skills to achieve greater independence.
7. Transitional services are outcome-driven.

Figure 1. Transitional Domains



1. **Employment and Career**
   - **a.** Competitive employment site
   - **b.** Work experience opportunities (e.g., paid placement at competitive worksite with co-worker mentor)
   - **c.** Supported employment (e.g., paid placement at competitive worksite with formal support, like a job coach)
   - **d.** Transitional employment opportunities (e.g., paid placement at a worksite that is formally set up for serving individuals with emotional/behavioral difficulties)

2. **Educational Opportunities**
   - **a.** Bachelor's degree or beyond
   - **b.** Associate's degree
   - **c.** Vocational or technical certification
   - **d.** High school completion or GED certificate

e. Work place educational programs (e.g., unpaid practicum with minimal, but necessary individualized supports)

3. Living Situations

a. Independent residence (e.g., living in an apartment with a roommate)
b. Residing with natural, adoptive, or foster family
c. Other family situation (e.g., girlfriend's family, extended family)
d. Semi-independent living (e.g., non-live-in service coordinator assists)
e. Supported living (e.g., supervised apartment)
f. Group home or boarding home
g. Restrictive setting (e.g., crisis unit, residential treatment center, detention center)

4. Community Life Functioning

a. Daily Living
  i. Self care
  ii. Maintenance of living space and personal possessions
  iii. Money management
  iv. Cooking and nutrition
  v. Maintenance and security of personal and financial documents
  vi. Safety skills (e.g., avoid dangerous situations, prevent victimization)

b. Leisure Activities
  i. Entertaining one's self
  ii. Activities with others
  iii. Creating indoor and outdoor activities of interest and fun
  iv. Places of entertainment and fun
  v. Safe and healthy activities (e.g., cyberspace safety precautions, safe routes for walking, biking, and driving at different times of the day, choice of friends)

c. Community Participation
  i. Transportation resources and skills
  ii. Knowledge of community resources
  iii. Citizenship responsibilities, knowledge of basic rights and responsibilities
  iv. Community social support (e.g., peer groups, community organizations)
  v. Access to legal services
  vi. Cultural and spiritual resources

d. Health
  i. Health care and fitness (e.g., physical activity, stress management)
  ii. Emotional/behavioral self-management (e.g., anger-control, acceptance of negative feedback, self monitoring, self-evaluation and self-control skills)
  iii. Self-management of substance use
  iv. Self-management of medications and knowledge of side effects
  v. Knowledge of sexual functioning and birth control (e.g., prevention of sexually-transmitted diseases and unwanted pregnancies)
  vi. Ability to access medical and dental services

e. Self-Determination
- **i.** Generate alternative options and make decisions
- **ii.** Set goals and develop plans for achieving such
- **iii.** Evaluate one's progress in achieving goals
- **iv.** Accept one's strengths and limitations
- **v.** Advocate for one's rights and positions

f. Communication
- **i.** Express one's ideas and feelings through speaking and listening
- **ii.** Reading and writing skills for learning, fun, and communication
- **iii.** Knowledge of information sources (e.g., use of library, authorities, Internet communications, and other resources)
- **iv.** Study and learning skills for gaining and applying new information
- **v.** Cyberspace safety (e.g., revealing personal information, meeting contacts in person, use of credit cards on-line)

g. Interpersonal Relationships
- **i.** Relationship development and maintenance of friendships
- **ii.** Balance of independence and interdependency with family members
- **iii.** Dating skills and development/maintenance of intimate relationships
- **iv.** Conflict resolution skills
- **v.** Maintenance of relationships with mentors and informal key players.

The TIP system is being continuously updated and improved upon by Dr. Hewitt B. Rusty Clark, Professor and Director, National Network on Youth Transition, University of South Florida; and Nicole Deschenes, B.Sc., M.Ed.; Co-Director. For the most current research and theoretical framework on the TIP system, please go to http://tip.fmhi.usf.edu and http://nnyt.fmhi.usf.edu

Please note that currently in 2009, the TIP system has been updated to include a new element of *Personal Effectiveness and Wellbeing* to the *Community Life Functioning* domain.

Figure 2. Transitional Domains, *revised 2009*

Personal Effectiveness and Wellbeing

a. Interpersonal Relationships: Family, Friends, & Mentors
b. Emotional and Behavioral Wellbeing
c. Self-Determination
d. Communication
e. Physical Health & Wellbeing
f. Parenting

B. Supportive Research Findings

The complex challenges of the transition period for young people with emotional disturbances and their unique needs pose major hurdles to parents, practitioners, educators, administrators, policy makers, and researchers alike. This situation presents compelling arguments for designing transition systems around a solid framework of promising strategies. Research findings regarding the best practices currently used by a number of promising transition programs in some communities across the nation are supportive of the TIP system and its guidelines (Bullis & Fredericks, 2002; Bullis, Morgan, Benz, Todis, & Johnson, 2002; Karpur, Caproni, Sterner, Whitfield, & Clark, 2003; Cheney, Hagner, Malloy, Cormier, & Bernstein, 1998; Cook, Solomon, Farrell, & Koziel, 1997; Clark, Pschorr, Wells, Curtis, & Tighe, 2004). Each of these studies report improved post-secondary progress and/or outcomes for the young people that were served using the TIP system or most of the TIP practices. In addition to the encouraging outcome research findings, each of the guidelines and elements have either empirical support, or broad professional consensus, indicating that these are at least promising practices for use with these young people with emotional disturbances and their families. Additional research that supports the TIP guidelines is in Appendix 1.

III. Project RECONNECT Administrative Elements

A. Logic Model

The Logic Model (see Appendix 2) as illustrated in Figure 3 demonstrates the relationship of population, challenges, and goals. In the *Population Frame*, the overall eligibility criterion envelops the sub-population the Project attempts to target. The *Challenge Frame* identifies challenges faced by youth, family, mental health system, social service system, and the community. The *Goal Frame* outlines the four overall goals: family and youth focus, inclusive planning process, stable and integrated system, and coordinated and quality services. These four overall goals wrap the specific goals for youth, family, mental health system, social service system, and the community.

Figure 4 is the *Strategy Frame* that illustrates the strategies to address challenges and to accomplish goals. It puts the young people at the center of the transitional services. The family, mental health system, social service system, and community surround and protect the young people. Each strategy is designed to empower and strengthen the respective element so successful transi-

tional services can be developed and maintained. The arrows across the five elements illustrate that each element influences and resonates with the others.

Figure 3. Utah Logic Model – Population, Challenges and Goals

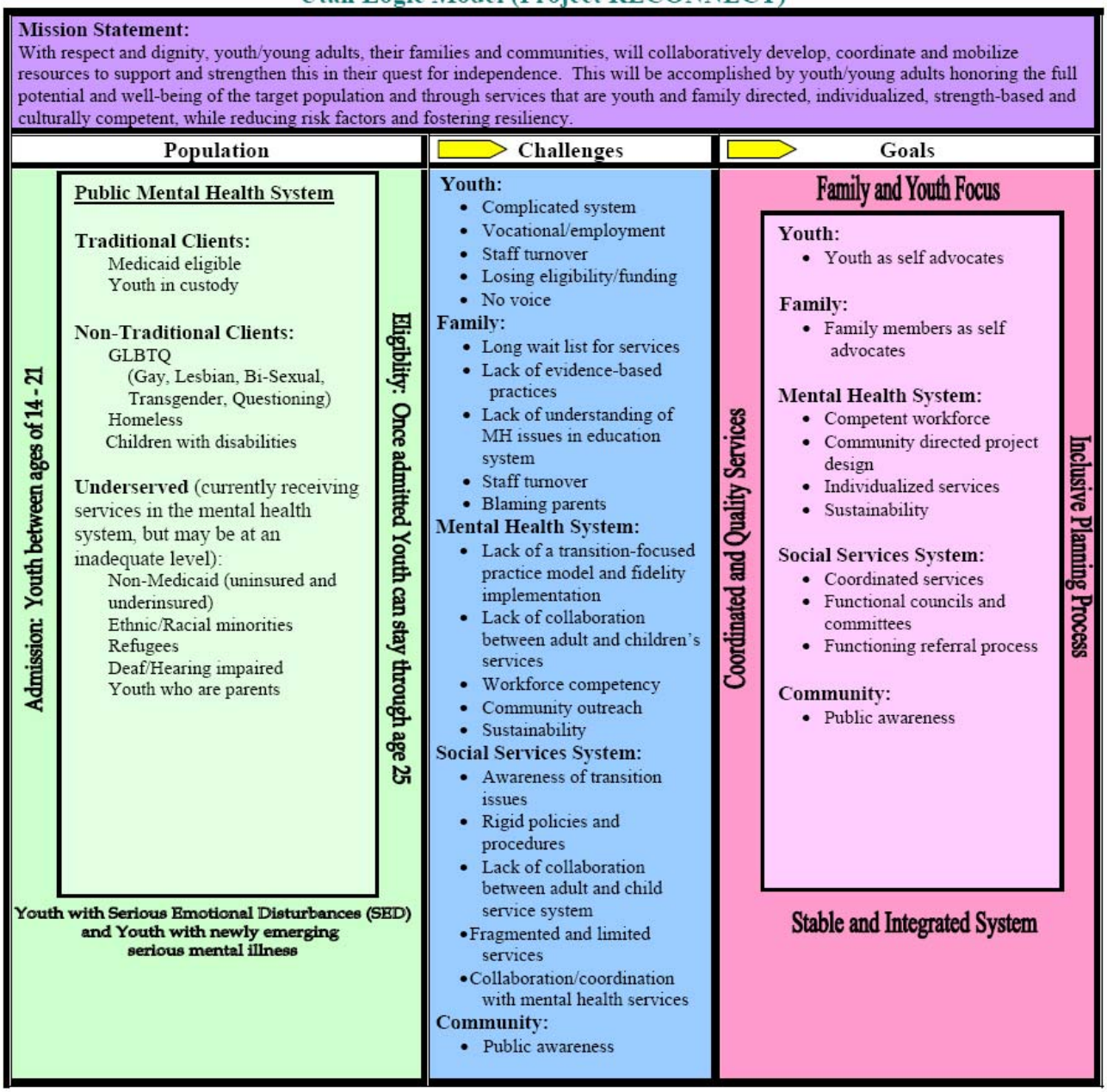
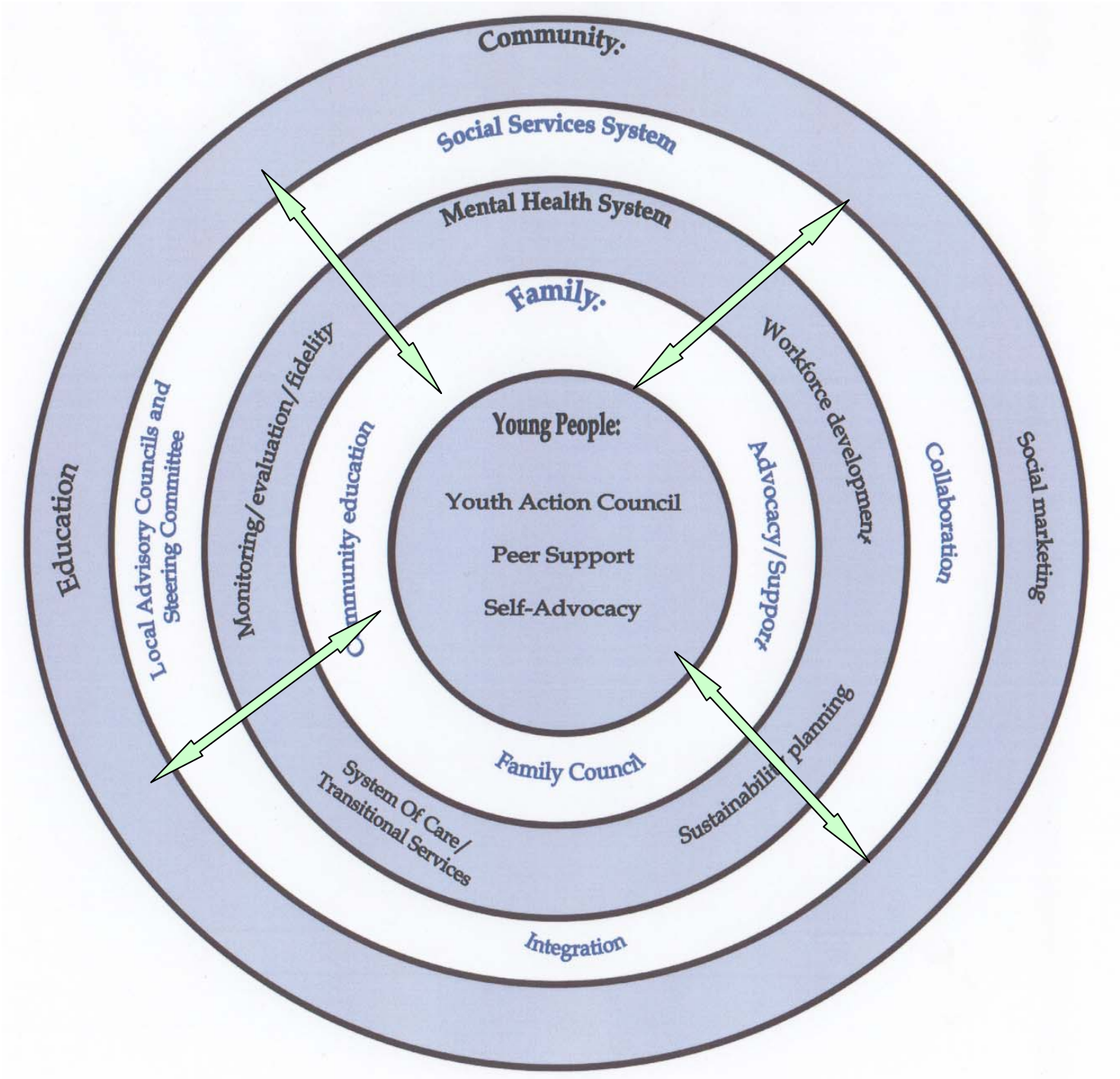


Figure 4. Utah Logic Model – Strategies



B. Eligibility / Admission Criteria

1. Overview of Project RECONNECT

There are two eligibility criteria that young people must meet to qualify for services:

- **a.** Age: Young people who are between the ages of 14 and 21 may be admitted into the program, but once admitted, they may continue in the program through age 25.
- **b.** Emotional Disturbances: Young people who are diagnosed with serious emotional disturbances (SED) in childhood or with newly emerging serious mental illness (SMI).

Following are the definitions of SED and SMI: (*Healthy People 2010, Chapter 18 Mental Health and Mental Disorders*, www.mentalhealth.samhsa.gov/features/hp2010/terminology.asp)

Serious Emotional Disturbances (SED):
SED is an inclusive term for diagnosable mental disorder found in persons from birth to 18 years of age that is so severe and long lasting that it seriously interferes with functioning in family, school, community, or other major life activities.

Serious Mental Illness (SMI):
SMI is an inclusive term for diagnosable mental disorder found in persons aged 18 years and older that is so long lasting and severe that it seriously interferes with a person's ability to take part in major life activities.

2. Adaptability for Replication

Aside from establishing an overall eligibility and admission criteria, there are some other considerations may impact access to services. For example:

- **a.** Insurance coverage: Some private insurance companies do not reimburse community and home-based services such as case management and care coordination, which are often significant components of transitional services.
- **b.** Bundling of services: Some companies require that all mental health services are obtained from the same provider. This may limit access to vital transitional services. For example, a young person may obtain medications, individual therapy and group therapy from a provider however that provider may not deliver other important supports such as case management, transitional facilitations, skills development, etc. This situation is cumbersome for the youth because in order for them to have success in their transition they need access to all services. The requirement of bundling services can be detrimental to their treatment goals.

3. Policy Implications

It is recommended that states and agencies review their policies and procedures to ensure that services for transitional aged youth are driven by the youth and family's needs/preferences and flow seamlessly between providers when needed.

C. Applicability of Practice with Special Populations

Project RECONNECT is based on the System of Care principles with strong cultural competency and family involvement emphases. Consistent with family driven youth guided care, the program is effective for young people and their families with diverse characteristics, including ethnic/racial minorities, refugees, deaf/hard of hearing, homeless, and sexual minorities. It is critical to ensure that communication does not present a barrier in service delivery, (i.e., providers are able to communicate with the service recipients in the same language, and qualified and skilled interpreters are available to assist in the communication.)

D. Collaborations with Non-Mental Health Service Providers

Project RECONNECT adopts a holistic approach in transitional services, encompassing four transitional domains: employment and career, living situation, educational opportunities, and community life functioning. A holistic approach requires a seamless system of care involving key partners in:

1. **Employment:** workforce/job services, vocational rehabilitation, businesses/employers.
2. **Living Situation:** housing authority, landlords, residential programs, shelter.
3. **Education:** schools, school districts, university/college/technical school.
4. **Community Life:** family members, relatives, friends and peer, natural and social support network, spiritual support, faith-based organizations, Boys and Girls Club, public aid, mental health and substance abuse providers, medical and dental providers, agencies serving diverse populations (ethnic/racial minorities, homeless, sexual minority, deaf/hard of hearing, refugee, etc.).
5. **Other Partners** such as Indian tribes, state and local public agencies in child welfare, juvenile justice, and disability issues, etc.

E. State and Local Collaborative

For transitional services to succeed there needs to be adequate focus at both state and local levels. Their roles and functions are complementary to ensure system attention, organizational competency, and resource allocation to this important program.

1. State Mental Health Authority

The role for the state mental health authority is to facilitate the development of a system where transitional programs receive attention and resources across children's services, including mental health, substance abuse, child welfare, juvenile justice, education, etc. The state's roles and functions include:

a. **Monitoring and Oversight:** Through monitoring and oversight, the state mental health authority ensures that the providers comply with the Federal and State regulations and establishes standards for the quality of care. The monitoring and oversight can be conducted through site visits, records review, and key stakeholder interviews. In Utah, the State mental health authority enters into contract with the community

mental health centers to provide transitional services. The contract outlines the scope of work to be performed by the community mental health centers (see Appendix 3).

b. **Training and Technical Assistance:** Monitoring and oversight can yield information of the strengths and challenges faced by the transitional services. Based on the information, the state mental health authority develops a technical assistance plan to assist the providers enhancing their strengths and overcoming challenges. The technical assistance plan is individualized and driven by the providers. As transitional services become more stabilized in the state, providers with "lived" experiences who are supportive of transitional services can be recruited to become peer consultants.
c. **Policy Development:** Through monitoring, oversight, and technical assistance, the state mental health authority may determine that certain issues are best addressed by policy. Often, the state mental health authority is prepared to engage in policy matters to support the community in transitional services.
d. **Interagency Collaboration:** Transitional services cross many domains, including mental health, substance abuse, employment, housing, and education, etc. The state mental health authority needs to work in a collaborative fashion with other state and local agencies, advocates and consumers.
e. **Evaluation:** The state mental health authority has the responsibility to develop a data infrastructure to evaluate the effectiveness, accessibility, quality, and outcome of the services. The evaluation will enhance the system's accountability and capacity for quality improvement.

2. Community Mental Health Centers

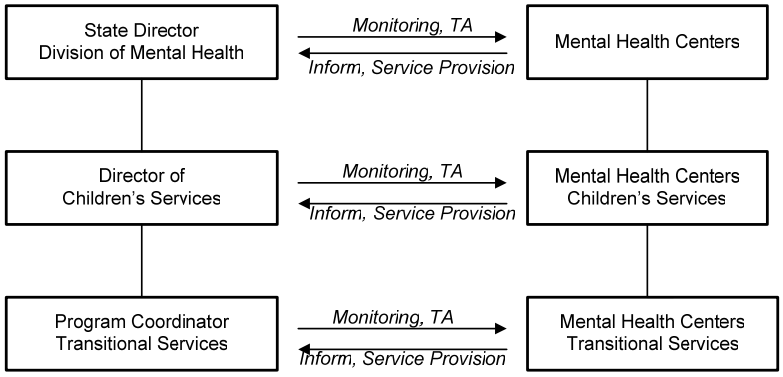
The core function of the community mental health centers is to provide services that are consistent with the practice guidelines for high quality care. They will do so by:

a. **Workforce Development:** Community mental health centers have the responsibility to assure a competent workforce to provide quality of care. Workforce includes leadership, management staff, supervisors, team leaders, line staff (clinicians, transitional facilitators, and case managers,) and support staff. Workforce competency will be assessed regularly and the training will reflect the advancement of the field. Good supervision and coaching is an integral part of the workforce development.
b. **Linking Young People and Their Families to Appropriate Services:** Screening and assessment provides the information to determine the critical services that are needed and desired by clients. Transitional services are considered for any youth between the ages of 14 and 21. Young people and their families are informed of the services available and they drive the treatment planning process.
c. **Mobilizing Community Partnership:** The needs of transitional youth cross many life domains. It is critical for mental health centers to mobilize community resources for well coordinated care. In doing so, young people can achieve wellness physically, mentally, and socially; and not just the absence of mental illness symptoms.
d. **Youth and Family Involvement:** Transitional services are youth-guided and family-driven. Treatment planning is strength-based.
e. **Cultural Competency:** Transitional services are appropriate for people from diverse cultural and linguistic backgrounds. Culture is an inclusive term, encompassing race,

ethnicity, disability, gender, sexual orientation, literacy, etc. Language access is available for people with limited English proficiency.

f. Inform: The mental health centers are in a unique position to identify emerging issues impacting transitional services through their direct interaction with the community partners, young people, and their families. When emerging issues or challenges are identified, mental health centers should inform the state mental health authority and they work collaboratively to develop solutions.

Figure 5. Collaboration between the State and Community Mental Health Centers

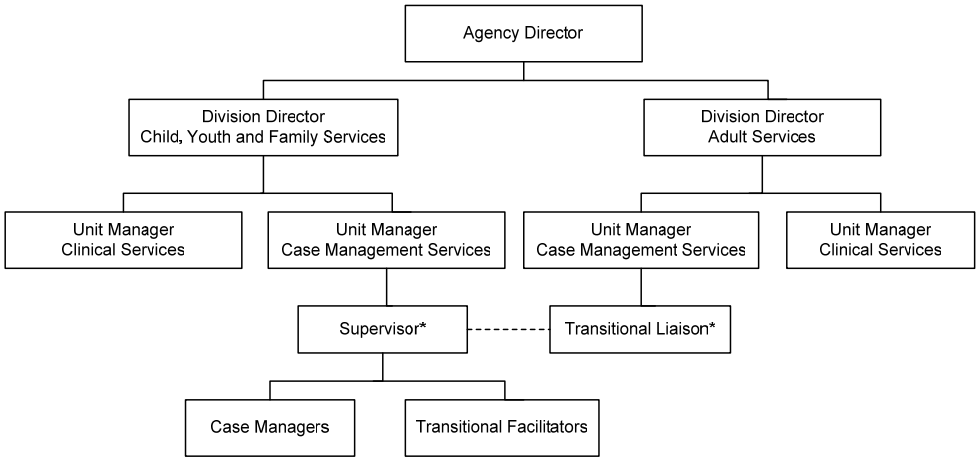


F. Management Structure and Staffing Pattern

1. Overview of Project RECONNECT

It is critical for the transitional services to be integrated into the organizational chart and structure so it receives adequate attention from the administration. Figure 6 shows the typical management structure of the transitional program in a large or mid-size urban agency.

Figure 6. Project RECONNECT at A Large or Mid-Size Urban Center

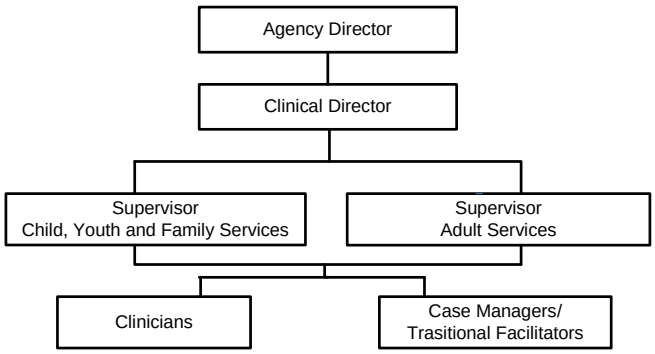


* The dotted line between the Children's Case Management Supervisor and the Adult Case Management Transitional Liaison indicates a collaborative working relationship.

2. Adaptability for Replication

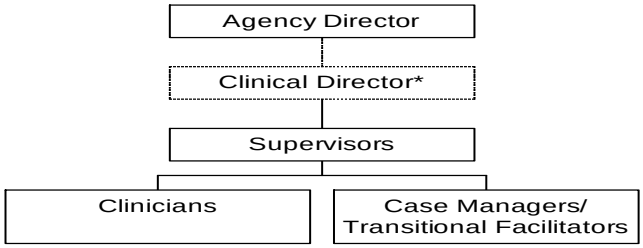
Under the umbrella of the overall management structure, agencies may also adapt the integration of transitional services according to the agency's size and organizational structure. For example, at a small urban center or a large to mid-size rural center, there may be different supervisors or team leaders for children's and adult services. However the clinicians, transitional facilitators, and case managers are more likely generalists who see both adult and children/youth.

Figure 7. Project RECONNECT at a Small Urban Center or Large to Mid-Size Rural Center



At a small rural center, there may not be the distinction between adult and children services. Clinicians and case managers are generalists who often serve both adult and children/youth. Most likely, there will be no dedicated transitional facilitators and clinicians or case managers double as transitional facilitators. In some small centers, there may not be case managers and clinicians provide case management and transitional services.

Figure 8. Project RECONNECT at A Small Rural Center



* The dotted line indicates that the position may or may not exist pending the agency structure.

G. Staff Roles, Functions and Training Requirements

1. Overview of Project RECONNECT

Adequate focus at all levels of organizations and staffing (state and local, administrators and line staff) is necessary to ensure that adequate resources are available for the transitional ser-

vices. It is important for line staff (clinicians, case managers, and transitional facilitators) to have administrative support and clinical supervision to deliver quality services. Job descriptions and staff qualifications for selected core staff (State Coordinator, Supervisor, and transitional facilitators) can be found in Appendix 4.

a. State Agency

A state coordinator should be employed to monitor the project operation, provide oversight and technical assistance to mental health centers, and ensure coordination and collaboration. The coordinator should have in-depth knowledge of the philosophy, structure and the intervention process of transitional services. The coordinator should also have comprehensive knowledge of the way service systems operate, including child welfare, juvenile justice, health, employment, and education.

b. Mental Health Center

The readiness for successful implementation of the transitional services requires an entire agency (including administrators, supervisors, line staff) to undergo a series of orientations and trainings.

i. Administrator:

The role of the administrator is to ensure that Project RECONNECT is fully functional within the agency by providing the program with necessary systematic and organizational support. To adequately perform that role, administrators should have overall familiarity with the philosophy and structure of the program, including operational guidelines, transition domains, and the intervention process. The administrator should also have thorough knowledge of the organizational issues; e.g., Steering Committee, advisory group, and resource development.

ii. Supervisor:

The role of the supervisor is to ensure that Project RECONNECT is implemented with fidelity to its philosophy, operational guidelines, and intervention process. The roles in the system include: 1) overall monitoring of the transitional services, 2) representing the agency in the Steering Committee and other community meetings, 3) developing and maintaining inter and intra-agency networks, 4) providing clinical supervision to the transitional facilitators, 5) identifying areas of strengths and deficiencies, 6) brokering technical assistance, 7) acting as the liaison between the transitional facilitators and the administration, 8) monitoring transitional facilitators' caseloads, and 9) providing transitional facilitators with the necessary resources and support to provide quality services.

To adequately perform their role, the supervisor should have thorough knowledge of the Project RECONNECT system. The supervisor should be involved in developing and monitoring the expected system, process, and performance outcomes. The supervisor should also have working knowledge of organizational issues; including Steering Committee, advisory group, and resource development; so they can assist the administrators in those areas.

iii. Co-Workers (including Clinicians and Case Managers):
Transitional facilitators should work in a multi-disciplinary setting for effective service coordination. Co-workers include social workers, psychologists, psychiatrists, nurses, case managers, family advocates, youth advocates and others. All should have working knowledge of the Project RECONNECT system and the intervention process, including operational guidelines, transitional domains, intervention methodology, inter and intra-agency collaboration, community development, family and youth development, and cultural competency so services can be coordinated. The co-workers should also be familiar with the eligibility criteria and the referral process.

iv. Transitional Facilitators:
Transitional facilitators achieve the goals of the Project RECONNECT through a "coaching style" of intervention across six major intervention components:

- Strength-Based Needs Assessment: Facilitators conduct strength-based transitional assessments and focus on the strengths, potential, and capacities of young people and their families to cope with problems in their lives to progress in a successful transition. The assessment process involves young people, their families, and other key people in the young people's lives.
- Transitional Planning: Facilitators work actively with young people, families, and stakeholders to develop transitional plans. The plan covers the four domains: education, employment, living situation, and community life adjustment. It matches young people to appropriate community settings and draw on strengths, potential, and capacity identified in the assessments.
- Service/Support Coordination and Advocacy: Service coordination is a very important function for facilitators because the TIP model emphasizes the provision of necessary, individualized services and supports in the context of the young person's community settings. Many youth-serving systems operate on different, even conflicting, philosophies and policies. This creates a fragmented system that meets its own needs, but not the needs of the young people and their families. Transitional facilitators assist young people to navigate service systems. They also assist adult systems in becoming more competent in serving transitional youth. The goal of case coordination and advocacy is to teach young people to be their own case managers and advocates.
- Monitoring: Transitional facilitators monitor the progress of young people in the four transitional domains: employment and career, living situation, educational opportunities, and community life functioning. The individualized transitional plans may be revised to meet the changing needs of the young people.
- Coaching, Mentoring, and Emotional Support: One important task for transitional youth is to develop skills and competency in handling adult independence and responsibilities. Facilitators are the keys to learning. They coach, mentor, create practice opportunities, and allow young people to experience natural consequences of their actions and life experiences. To facilitate developmentally appropriate learning, transitional facilitators identify individual young people's behaviors, emotions and cognitive abilities and how these factors influence learning. Such factors include depression, hostility, withdrawal, and aggression, etc. Special attention also should be paid to personal-

ity traits, such as borderline and anti-social that may become apparent as young people approach adulthood. Transitional facilitators need to be proficient in recognizing different personality traits and have access to coaching and supervision in working effectively with these personality traits.

- Community and Natural Supports: Facilitators may be the primary support in the beginning of the transition. Facilitators help link young people with other supports and assist them in sustaining these supports.

It is critical for agencies to recognize that transitional facilitators function differently than traditional case managers. Services provided by transitional facilitators are a proactive form of case management. Facilitators provide case management functions of coordinating, linking and monitoring services. Facilitators function as coaches, mentors, and critics to assist young people to learn functional and adaptative behaviors that are critical for transitioning into adulthood. Facilitators provide constructive and helpful feedback, model behaviors, convey an optimistic and positive outlook, and express encouraging and affirmative comments. Many case managers at the mental health centers do provide coaching and bill such activities as skills development or psychosocial rehab instead of case management.

Roles and Functions	Case Managers	Transitional Facilitators
Coordinate, link, and monitor services	X	X
Teach and coach		X
Illness recovery		X
Advocate	X	X
Crisis Management	X	X
Transportation	X	X
Developing support system	X	X
Role model/mentor		X
Record keeping	X	X

Transitional facilitators should have in-depth knowledge in:

- Project RECONNECT system intervention process including operational guidelines, transitional domains, and intervention methodology
- Community resources in the transitional domains
- Case management skills
- Child development and youth development theory and practice
- Family and youth empowerment
- Building community partnership
- Casey Life Skills Training
- Crisis intervention, including crisis and safety planning
- Code of ethics (including confidentiality issue) and boundaries
- Cultural competency
- Working effectively with people who have major mental illness, including those with different personality disorders or traits

2. Adaptability for Replication

It is common for some agencies to have staff assume multiple responsibilities. For example, administrators also function as supervisors, or case managers function as transitional facilitators carrying a small caseload of transitional youth. In some centers, there may not be case managers, so clinicians conduct case management services. Under such circumstances, it is important to assure that all transition-related functions are carried out with fidelity by clinicians. Although not impossible, it is usually not very feasible or practical to expect clinicians to function as transitional facilitators due to the demand on the facilitators.

H. Supervision and Consultation

1. Overview of Project RECONNECT

Transitional facilitators' responsibilities are challenging; they often deal with difficult and unexpected situations. Supervision and support are critical in ensuring the quality of services and preventing burnout. For agencies that employ multiple facilitators, there should be bi-monthly group supervision at a minimum, with a lead facilitator or supervisor to coordinate supervision and training activities. Most transitional facilitators are housed in the case management unit and a Licensed Clinical Social Worker (or other licensed mental health professional) provides the group supervision. Group supervision is a great source for clinical and emotional support. Through case presentations, facilitators become familiar with other facilitators' cases and they can share backup and on-call responsibilities.

2. Adaptability for Replication

For agencies that do not have multiple transitional facilitators, or use other clinical staff to carry small caseloads of transitional youth; group supervision on transitional facilitation may not be feasible. One-on-one supervision or case management group supervision may suffice, as long as transitional facilitation receives adequate attention in supervision.

I. Facility Design

1. Overview of Project RECONNECT

Transitional facilitators should have their individual offices and access to group rooms for family team meetings. The set-up of individual offices should ensure privacy and confidentiality (e.g., doors, private phone lines, and locked file cabinets, etc.).

2. Adaptability for Replication

Transitional facilitators do much of their work in the field, e.g., schools, coffee shops. It is important for them to have access to equipment and internet for easy record keeping and to search for web-based information. Equipment may include a Personal Data Assistant (PDA), cell phone, pager, and laptop computer to assist facilitators in performing job tasks effi-

ciently. If possible, laptops should have wireless internet capabilities to assist facilitators in accessing web-based information (e.g., Ansel Casey Life Skills Assessment) they can use in meeting with young people and families.

J. Caseload

1. Overview of Project RECONNECT

It is recommended that the maximum caseload per facilitator is **15**, with five (5) young people in active coaching, five (5) in maintenance, and five (5) in the follow-up phase. Active coaching is in-person contact daily, or at least every couple of days. Maintenance stage is one to four in-person contacts per month. Follow-up is contacts by phone or in person once per month, to once every three months.

2. Adaptability for Replication

The transitional cases can be assigned to individual facilitator or to the team of facilitators. A team can allow different facilitators see young people on different days. The one-to-one facilitator-youth assignment may promote relationship development, but there may also be a negative side effect of creating dependence on one person. Some facilitator teams find that a facilitator-youth rotation system promotes less dependency on the part of the young people and a reasonable distribution of workload. This allows young people to select a facilitator to assist with certain activities. For example, a female young person may feel uncomfortable going to a doctor's appointment with a male facilitator.

It is most critical to ensure that the caseload size allows the facilitator to provide adequate attention and support to each young person. Each young person should receive adequate individualized services appropriate for their level of functioning and developmental milestone. Therefore, the caseload should be flexible. Facilitators should communicate with supervisors when the caseloads become difficult to manage. Supervisors should constantly monitor the caseloads to ensure that it takes into account the characteristics of cases and the facilitator's limitations. Following are some factors that may impact the size of the caseload:

a. **Location:** Transitional facilitators do much of their work in the field, e.g., schools, home. Traveling is a big part of the job. The caseload needs to be adjusted if traveling to young people's location is time consuming.
b. **Severity level of behavioral or emotional difficulties:** The caseload needs to be adjusted if the facilitator has in his/her caseload young people who are fragile or unstable. These young people may occupy a great deal of the facilitator's time and energy.
c. **Degree of stability in their home, school, and/or employment placements.**
d. **Lack of formal and informal supports for the young people.** Before the young people have adequate formal and informal support network in place, the facilitator is the main person to provide and coordinate key transitional services and it can take up the facilitator's time and energy.

K. Flexible Funds

1. Overview of Project RECONNECT

Flexible funds have become an essential element in transitional services. Flexible funds are funds available to young people and their families in assisting them to obtain the necessary services or resources to facilitate a successful transition. With these funds, facilitators can address the specific transitioning needs of youth where no other traditional funding could otherwise be utilized for that purpose. Examples of how funds can be used include: one time deposit, first month rent, utilities, job-related tools or uniforms, furniture or personal items, and transportation (bus passes, vehicle repair), etc. This is typically one-time assistance only. No inpatient or residential care will be paid for by flexible funds. It is important that flexible funds are accessible in a simple and timely manner, but also the tracking of these funds should be thorough.

Examples of unacceptable funding usage include: entertainment, extracurricular registration fees, and Sub-for-Santa gifts, etc. If these types of services are needed by the young people and their families, financial arrangements should be made by developing partnerships with local organizations such as United Way, church groups, business, and community organizations, etc. The following are the project guidelines in disbursing flexible funds (see Appendix 5 for sample flexible funds protocol):

- **a.** The supervisor and project staff approve fund requests.
- **b.** The turn around for approval is less than 24 hours.
- **c.** The amount is approved for the "**payee**" only, or payment will be made directly to the Vendor/Provider that is providing the services.
- **d.** All requests need to include the client name and the reason for the request,
- **e.** Incomplete forms will be returned to the worker.

2. Adaptability for Replication

Depending upon the fiscal operation procedures, agencies may develop a flexible funds request and disbursement process that is compliant with the agency's policies and procedures.

L. Program Costs

1. Overview of Project RECONNECT

The following costs are an estimate on a project of eight (8) full-time transitional facilitators. Project RECONNECT based this number upon the Utah labor market from 2002-2007. Costs shown here were calculated on annual basis and divided into the following categories:

a. Personnel

i. Administration and Management

At the state level, there is a Program Coordinator to provide oversight and statewide coordination to the project. In the initial development phase of the project (usually the first two years), a full time Program Coordinator is employed to ensure that the system and clinical components are in place and functioning. As the Project becomes more stabilized, the Program Coordinator can be reduced to ½ Full Time Equivalent (FTE). At the mental health center, a full time Supervisor is employed during the first two years and the position is reduced to ½ FTE as the project becomes stabilized.

Administrative and management staff cost:

Year one and two	Low Range	High Range
1 FTE State Program Coordinator	$ 40,000	$ 44,000
1 FTE Local Supervisor	$ 35,000	$ 38,000
Fringe Benefit (30%)	$ 22,500	$ 24,600
Subtotal	**$ 97,500**	**$106,600**

Year three and four	Low Range	High Range
½ FTE State Program Director	$ 20,000	$ 22,000
½ FTE Local Supervisor	$ 18,000	$ 19,000
Fringe Benefit (30%)	$ 11,400	$ 12,300
Subtotal	**$ 49,400**	**$ 53,300**

ii. Transitional Facilitator

Project RECONNECT employed eight (8) full time transitional facilitators.

Year one and on	Low Range	High Range
8 FTE Facilitators ($28,000 each)	$ 224,000	$ 250,000
Fringe Benefit (30%)	$ 67,200	$ 75,000
Subtotal	**$291,200**	**$ 325,000**

b. Equipment

All personnel should have a computer with internet connectivity. Program Coordinators and Supervisors are office-based positions, as a result a desktop computer and regular phones are adequate for their needs. Facilitators should have cell phones, Personal Data Assistant (PDA), and laptop computers with wireless capability since they do so much work in the field.

Year one	Low Range	High Range
Two (2) desktop computers	$ 4,000	$ 5,000
Eight (8) laptops	$ 16,000	$ 24,000
Eight (8) cell phones	$ 0*	$ 2,000
Eight (8) Personal Data Assistant (PDA)	$ 3,200	$ 4,000
Subtotal	**$ 23,200**	**$ 35,000**

* Some companies offer cell phones for free when signing up a cell phone plan.

c. Training

A training budget should allow project personnel to attend training conferences on transitional issues annually. Each Project can either organize trainings offered locally or send project personnel to regional or national conferences. The average training budget for each person is estimated to be $500.

Year one and on	Low Range	High Range
Training for 10 staff	$ 5,000	$ 7,000
Subtotal	**$ 5,000**	**$ 7,000**

d. Technology Services

Technology services include computers and network related maintenance and security, etc. It is estimated to be $100 - $130 per month per staff.

Year one and on	Low Range	High Range
Technology services for 10 staff	$ 12,000	$ 15,600
Subtotal	**$ 12,000**	**$ 15,600**

e. Communication

Communication is phone charges, including office and/or cellular service. It average $35 to $45 a month.

Year one and on	Low Range	High Range
Phone charges for 10 staff	$ 4,200	$ 5,400
Subtotal	**$ 4,200**	**$ 5,400**

f. Office Supplies

Supplies include office supplies, mailing, printing, books, and resource materials. The average of supplies for each staff is $500.

Year one and on	Low Range	High Range
Supplies for 10 staff	$ 5,000	$ 7,000
Subtotal	**$ 5,000**	**$ 7,000**

g. Flexible Fund

The flexible funds are estimated at $400 per year per young person. An average of 120 young people will receive services annually in a project that employs eight (8) transitional facilitators.

Year one and on	Low Range	High Range
Flex fund for 120 youth	$ 48,000	$ 55,000
Subtotal	**$ 48,000**	**$ 55,000**

h. Community Partnership Development

The community partnership development fund is for mobilizing community support and engagement in the project. These include meeting expenses, stipends for Family and Youth Council members, and community training events. The recommended stipend for Family and Youth Council members is $25 for every two hours of activities.

Year one and on	Low Range	High Range
Meeting expenses	$ 1,000	$ 1,200
Stipend	$ 4,000	$ 4,500
Community training	$ 1,000	$ 1,300
Subtotal	**$ 6,000**	**$ 7,000**

i. Total Expenses

The following is an estimated budget for operating expenses of a transitional team with: a Program Coordinator, a Supervisor, and eight (8) transitional facilitators.

	Low Range	High Range
Year One	$492,100	$563,600
Year Two	$468,900	$528,600
Year Three	$420,800	$475,300
Year Four	$420,800	$475,300
Total	**$1,802,600**	**$2,042,800**

2. Adaptability for Replication

This costs analysis was based strictly on the Utah labor market from 2002-2007. It may be more or less expensive to operate a project of similar size in other states, pending the cost of living expenses, and available community resources that may be allocated to the project. Technology services and communication should be regularly reviewed to ensure costs are meeting the program needs of the youth. For example: text messaging has become a preferred communication mode for young people since 2007. Cell phone plans for transitional facilitators should also include text messaging besides the normal voice mail as a means to maintain contact with youth and families.

IV. Project RECONNECT System Elements

A. Principles of System Development

The principal of system development is *interdependence*. This term means ***a reciprocal relation between interdependent entities (objects or individuals or groups)*** (WordNet, 2003).

Jacqueline Grennan Wexler said, “Today, the mission of one institution can be accomplished only by recognizing that it lives in an interdependent world with conflicts and overlapping inter-

ests" (American Heritage Dictionary, 2006). Interdependence is especially critical for transitional services because of how the needs of transitional youth encompass all major service systems.

Effective transitional services require the transformation of the mental heath system into a system that practices interdependence at all levels: legislative, policy, funding, training, services, evaluation, and accountability. Such a system should reflect the following characteristics:

1. Seamless intra-agency collaboration between the adult and youth providers.
2. Community development that fosters comprehensive interagency collaboration among mental health, substance abuse, education, child welfare, juvenile justice, workforce development, housing and other agencies.
3. Family development that recognizes a family's critical need for support for the transitional youth, and the changing role it plays in the young person's life.
4. Youth development that encourages young people's independent voice and participation.
5. Cultural competency that ensures that services are available, accessible, and appropriate for young people with cultural and linguistic diversities. Cultural diversities may include ethnic/race, refugee, disability, homelessness, and sexual orientation, etc.

B. Intra-Agency Collaboration

1. Overview of Project RECONNECT

For many years, the children's mental health system sought to distinguish itself from adult system and to develop services that are developmentally appropriate and family-driven. As a result, many mental health centers in Utah established a Children's Services unit to provide better specialized children and youth services. As children's mental health services became more specialized, it inevitably became separated from the adult services system to meet the need of children and youth. Children and adult systems often have different philosophies and programming regarding the delivery of services. The lack of collaboration between these two systems can be detrimental to successful transitional services for youth. Some barriers to a seamless collaboration between the two systems may include:

a. General lack of awareness of transitional issues by adult and children's systems.
b. Eligibility issue: Often, eligibility for children and adult services is based on age. Young people are transferred to the adult system at 18. There is little consideration of the developmental capability of the youth and/or his/her readiness for adulthood. Another factor to consider is that young people who meet the criteria for "Serious Emotional Disturbance (SED)" may not meet the criteria for "Sever Mental Illness (SMI)". However, they may still need support services to maintain a successful transition into adulthood.
c. The two systems may differ. The children's system may be oriented towards strength-based youth development, strongly supports a "system of care" model, and also places a high value on family involvement. Some of these core concepts found in children's system are not always well integrated into the adult system.
d. Confidentiality issues often hinder family involvement and case coordination when the young person turns 18. A young person may still be living with his or her parents

and yet upon turning 18, the parents are no longer able to access client information or participate in treatment support without formal consent from the young person.

e. Care coordination is often implemented differently in the children and adult systems. Adult services often view care coordination as the consumers' responsibilities, while children services take a more active role in care coordination. Adult services may limit the coordination to social services, e.g., employment and housing; while coordination for children services expands to other non-social service areas, e.g., education.

The following is a process to develop seamless intra-agency collaboration between the adult and children/youth services:

a. Policy and Procedure

Transitioning is an incremental and sequential process. The agency should develop policy and procedure to allow easy and gradual transitioning from the children/youth system to the adult system within the agency. One example is the overlapping of services that allows young people to remain in the children's services until age 21.

b. Cross Training

The adult system receives training on child development theory, youth and family driven care, person-centered planning, care coordination that encompasses all life domains, transitional issues, and evidence-based practices for children and youth. Training provided for staff from the children/youth system, needs to focus on understanding the infrastructure and philosophy of care of the adult system. In doing so, they can effectively assist young people and their families to maneuver through the adult system. Each of the staff from these systems receive training on maintaining confidentiality while involving families when young people become adults.

c. Cross Staffing

Team members from both the adult and children/youth systems should attend staffing on each transitioning youth to facilitate care coordination.

2. Adaptability for Replication

For large mental health centers that serve a significant number of transitional youth, it may be constructive to establish a Transitional Services Team to implement these specialty services. For small mental health centers that do not have separate adult and children/youth services, intra-agency coordination may not be as significant an issue because staff sees both children and adults. However, these small centers should still closely examine the aforementioned areas to ensure that transitional issues are adequately considered in service planning.

C. Community Partnership Development

1. Overview of Project RECONNECT

Community partnership development should foster comprehensive interagency collaboration at administrative, management, and direct care levels. A well-organized and represented **State Steering Committee** is critical in mobilizing support and developing formal linkages with community partners. Community partners are agencies, organizations, groups, and individuals that have an impact on transitional services. These include, but are not limited to: mental health, substance abuse, education, child welfare, juvenile/criminal justice, law enforcement, workforce development, health, housing, private businesses and employers, faith-based organizations and spiritual leaders, community-based organizations (including culturally diverse groups), advocates, young people, and family members, etc. The process to organize the Steering Committee is flexible and continuous. New members can be included at anytime so the committee can stay responsive to the multiple and changing needs of the young people and the community.

The responsibilities of the State Steering Committee may include, but are not limited to:

- **a.** developing a mission statement,
- **b.** developing formal partnerships,
- **c.** developing service coordination mechanisms, and
- **d.** monitoring the planning, implementation, and evaluation process.

The Steering Committee may also assist in identifying and acquiring funding to sustain transitional services. This committee may meet on a monthly basis to provide project oversight in the planning and initial implementation phase. As the project becomes more stabilized, the meetings can be reduced to bi-monthly, quarterly, or semi-annually basis. The decision-making process for the Steering Committee is negotiation and consensus building when possible; therefore, it is helpful if someone skilled in consensus facilitation be part of the group's structure. If necessary, voting can be used but it is done carefully to avoid dissenting opinions and resistance to the decision.

2. Adaptability for Replication

Organizing **workgroups** is a way to keep the State Steering Committee inclusive but also manageable in size. Workgroups are formed to address specific issues, such as housing and education. Workgroups meet regularly to develop strategies within their focus areas. A representative from each workgroup attends the Steering Committee and brings workgroup recommendations to the Steering Committee. The Steering Committee then consolidates all recommendations into an integrated strategic plan through negotiation and consensus building. The process to organize workgroups is flexible and continuous. New groups can be formed anytime so the project stays responsive to the multiple and changing needs of the target populations and the community. For example, a mental health workgroup can be organized to assess the current mental health system's capacity and gaps, identify barriers and opportunities, develop recommendations, and identify evidence-based practices, etc.

Some projects may have multiple service sites covering various geographical areas that have very different needs. For instance, a project that includes both rural and urban settings may have to assess what the individual needs of a community may be. It is advisable to organize a **Local Advisory Councils** in addition to the Steering Committee. Membership of the Local Advisory Council should reflect the characteristics and the needs of the local community. For example, a metropolitan city may need to outreach to the homeless community, but a rural town may need to improve outreach on a nearby reservation of an Indian tribe. The responsibilities of the Local Advisory Council are similar to the State Steering Committee, but can also take on additional responsibilities of things like direct service coordination for transitional youth cases that require interagency coordination.

D. Family Development

1. Overview of Project RECONNECT

a. Family Council

A successful transitional project should prioritize and value family development. A project should recognize the family's need for critical support of the transitional youth, and the changing role it plays in the young person's life. Therefore a **Family Council** is an intricate component for the project. This council provides family members and care givers a forum to provide input to the overall direction of the project, and to develop strategies for family involvement. The Family Council reviews policies and procedures to ensure adequate family focus, reviews project reports, and assists in the interpretation of outcome data. Two Family Council representatives attend the Steering Committee.

The Family Council meets monthly. It is critical that Council members receive leadership training so they can adequately and confidently carry out their responsibilities. Family Council members are professionals who bring to the project the "lived" experience and subsequent expert knowledge and skills of being family members. These members should be treated like professionals. Stipends should be provided to help compensate for their time and effort.

b. Family Education

It is often difficult for family members to adjust to the changing roles they play in the young person's lives as they gain independence. In Project RECONNECT, the Family Council developed a curriculum for parents and caregivers with transition age youth (see Appendix 6). It provides family members and caregivers a tool to help young people with mental health challenges to negotiate the road to adulthood. It covers following topics:

- **i.** Taking care of yourself
- **ii.** Person-Centered Planning
- **iii.** Education
- **iv.** Legal Issues

v. Dreaming New Dreams/Loosing Up
vi. Developmental Milestones
vii. Transitional Timeline Checklist
viii. Foster Children

2. Adaptability for Replication

The curriculum is a live product. Content should be regularly reviewed to ensure that it remains relevant to parents and caregiver. Before an agency adopts this curriculum, it is critical to have local family members review it and adapt it for the local cultures and needs. It may also be necessary to coach the Family Council on youth empowerment.

E. Youth Development

1. Overview of Project RECONNECT

Youth development values input from young people and actively solicits their independent voices. A **Youth Council** is organized to provide young people a forum to give input to the overall direction of the project and to develop strategies for youth involvement. Like the Family Council, the Youth Council reviews policies and procedures to ensure adequate youth focus, review project reports, and assist in the interpretation about outcome data. Two (2) Youth Council representatives will serve on the Steering Committee.

The Youth Council meets on a monthly basis. It is critical for Council members to receive leadership training so they can adequately and confidently carry out their responsibilities. Youth Council members bring expert knowledge and skills of being transitional youth and should be treated like professionals. Stipends should be considered to help compensate for their time and effort. Transportation is a major factor that can impact meeting attendance and assistance could be provided in the form of bus tokens. The transition facilitators are allowed to provide transportation, but they are encouraged to empower young people to take that responsibility. A meeting location should be carefully selected to minimize the transportation barrier. Public libraries are ideal places for meeting because they usually have public meeting rooms and are located near public transportation.

It is critical to consider the issue of liability when conducting youth development. It is a delicate balance between the concern for liability and the need to allow young people practice independence. The Youth Action Council should be oriented to the concept of liability and understand the limitations it may place on the project. It is possible to achieve the balance through careful examination of the youth development activities and negotiation with young people and project staff.

2. Adaptability for Replication

It is important to look at the community cultures and environment to identify the diversities to be represented in the Youth Council. Diversities are inclusive of race/ethnicity, language,

gender, sexual orientation, disability, homelessness, faith and spirituality, and foster care, etc. Sexual orientation is an issue for many transitional youth and warrants adequate attention.

F. Cultural Competency

1. Overview of Project RECONNECT

a. Cultural Competency Advisory Council

The project has a Cultural Competency Advisory Council that is responsible to develop strategies to address cultural competency issues. The Advisory Council examines policies, procedures, clinical practices, and the evaluation to insure that they are appropriate for diverse cultures. It develops strategies to address cultural and linguistic diversity issues. The Advisory Council consists of representative from ethnic/racial minorities (Hispanic, Native American, African American, Asian, and Pacific Islander), refugees, people who are deaf or hard of hearing, homeless and sexual minorities. The Council meets monthly the first two years and then on a quarterly basis afterwards.

b. Cultural Competency Practice Model

Project RECONNECT developed the "Cultural Competency Practice Model" that is used to guide system development and clinical practices (see Appendix 7). The Practice Model addresses issues of guiding principles, knowledge development, and skills enhancement.

2. Adaptability for Replication

It is important to look at the community cultures and environment to identify the diversities that should be represented in the Cultural Competency Advisory Council. Diversity foci include, but are not limited to; race, ethnicity, immigration status, language, gender, sexual orientation, disability, literacy, homelessness, religion, spirituality, and foster care, etc.

V. Project RECONNECT Clinical Elements

A. Principles of the Practice

Project RECONNECT adopts the seven TIP system principles, which are similar to the System of Care:

1. Person-centered planning is driven by young people's interests, strengths, and cultural and familial values. Young people and family involvement are integral parts of the process. It is important to recognize that cultures are comprised not only by race and ethnicity, but also other factors such as age for youth culture. Cultures are to be respected and incorporated into the transitional plan.
2. Community inclusion environment will assist young people to function in the whole community and in the least restrictive setting.

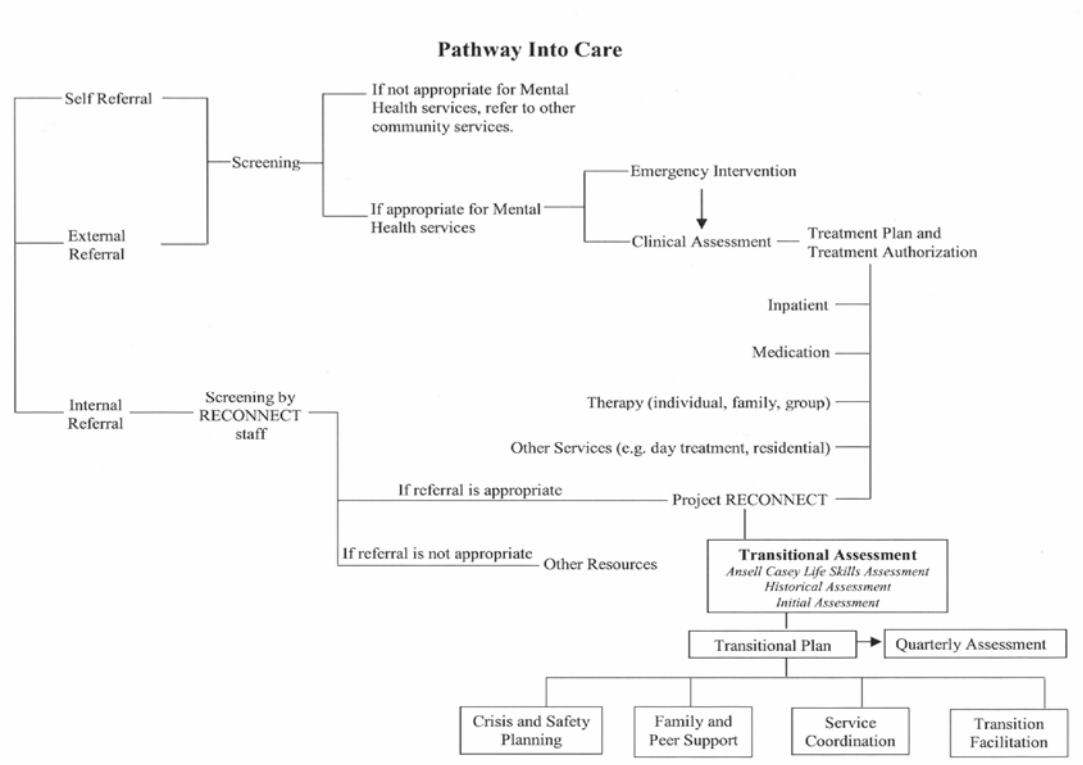
3. Services and support must be individually tailored and comprehensively designed to encompass all transitional domains. Young people need to gain competency in all domains to successfully transition to adulthood.
4. Services and support need to be coordinated to provide continuity from young people's perspectives. They should meet the needs of young people rather than young people meeting the needs of service systems.
5. A safety net of support expresses hopefulness and guarantees commitment by staff, other service providers, and support systems. Flexible boundaries appropriate for developmental stages are important to assist young people to master developmental tasks and to gain maturity.
6. Young people need to acquire relevant skills to achieve greater independence.
7. The TIP system must be outcome-driven.

B. Pathway Into Care

1. Overview of Project RECONNECT

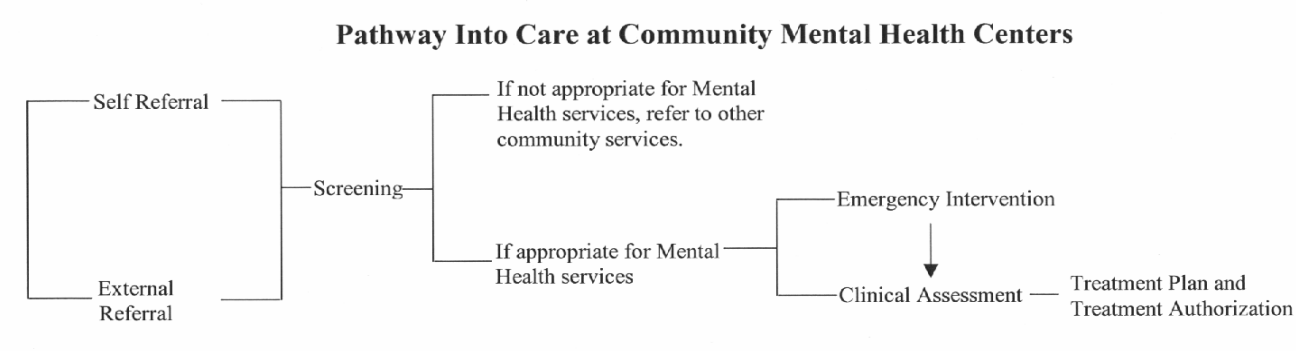
Figure 9 illustrates the typical pathway into care from initial referral to receiving transitional services from Project RECONNECT.

Figure 9. Pathway Into Care



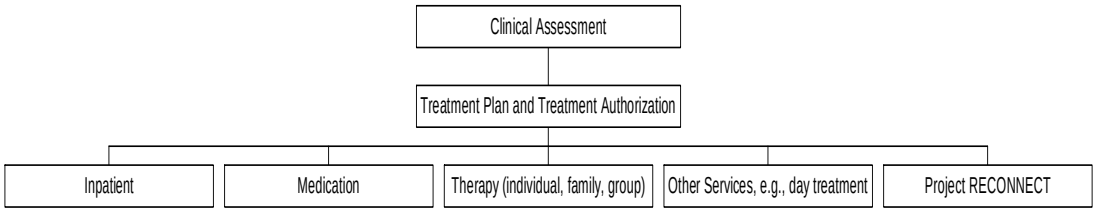
Typically, young people need to be an active client at the community mental health center to receive services from Project RECONNECT. Figure 10 illustrates the pathway into care at the mental health center.

Figure 10



After the young person becomes an active client at the mental health center, he/she is referred to Project RECONNECT for transitional services if it is authorized in the treatment plan (see Appendix 8 for sample internal referral form). Young people and their families participate in the development and review of the treatment plans. The decisions to enter into Project RECONNECT are jointly made by the young person, family members, and the staff. Figure 11 illustrates the pathway into care of Project RECONNECT when the young person is an active client at the mental health center.

Figure 11. Clinical Process for Project RECONNECT participants



2. Adaptability for Replication

Pathway into care is often restricted by agency's policy, procedures, and funding streams. Each community has its own pathway into care based on those restrictions. It is critical to examine the pathway for its accessibility for transitional youth. One population that often has limited access to community mental health centers is the non-Medicaid eligible. Community mental health centers are best positioned to provide transitional services because of the comprehensive array of services they offer. It is critical to examine the pathway into care at the community mental health centers for its accessibility to young people with different funding sources (Medicaid, private insurance or no funding).

C. Social Marketing and Outreach

1. Overview of Project RECONNECT

Children and young people with serious emotional disturbances (SED) are critically underserved by both public and private resources. To be successful, the program needs to develop

a comprehensive referral network, and be creative in reaching the target population and engaging them in services. The referral network includes public and private organizations providing services in mental health, substance abuse, child welfare, education, juvenile justice, and health. It also include community groups such as ethnic/racial communities, faith communities, the homeless shelter, and most importantly, young people and families themselves. The Steering Committee, Local Advisory Council, Family Council and Youth Council are also important sources for referrals.

Following are several methods to increase the community's awareness and understanding of the project:

a. Brochure or Pamphlet:
The brochures or pamphlets should be informative and persuasive. Material should be appealing with photographs to illustrate that the project is about the young people we serve. It succinctly describes the project, including mission, vision, objectives, services, and contact information. Contact information includes agency name, address, phone number, web site, and staff name. A sample of the pamphlet is included in Appendix 9.

b. Web Site:
A website can provide information about the project comprehensively, and link visitors to related sites and resources. It is critical to keep the web site current. Some suggested keywords for the web site are: transition, adulthood, Serious Emotional Disorders (SED), independent living, life skills, Individual Educational Plan (IEP), and Individuals with Disabilities Education Act (IDEA).

c. Coordination Meetings:
To facilitate outreach, there should be regular communication with community partners so they have complete and adequate understanding of the project. The Local Advisory Council can be very effective to facilitate referrals.

2. Adaptability for Replication

With the advancement of technology that changes how people communicate and network, agency and program should always investigate new and innovative methods for social marketing and outreach. Some examples include social networking web sites, which are very popular among young people. Care should be taken to ensure that the social networking web sites are not misused for inappropriate information exchange.

D. Referral

1. Overview of Project RECONNECT

There are typically three types of referrals: *self-referral*, *external referral*, and *internal referral*. *Self-referrals* are referrals that are made by young people themselves and/or their families. *External referrals* are made by outside agencies or individuals who are familiar or work with the young person to be referred. Both self and external referrals need to go through a

standard screening and assessment process to be opened as active clients at the mental health center. After becoming an active client, the young person can then enter into Project RE-CONNECT for transitional services.

Internal referrals are referrals made by other services within the mental health center for young people who are already open at the mental health centers. These young people can enter into Project RECONNECT immediately as long as the appropriate treatment authorization is in place.

2. Adaptability for Replication

It is important to examine the referral process to make sure that it does not present unnecessary barrier for self and external referrals.

E. Screening

1. Overview of Project RECONNECT

Screening is a standard mechanism employed by the mental health centers to ensure that the child or young person's individual needs are adequately considered. The purpose of screening is to determine if mental health services should be considered for children and young people. It also determines if a more comprehensive mental health assessment is needed, how timely the assessment should be, or if an emergency intervention is warranted. Those who are screened as not appropriate for mental health services, may be referred to other community resources more appropriate for their needs.

Typically, the screening is performed on the phone. A secretary collects demographic information and a licensed clinician conducts a brief screening using a screening guide (see Appendix 10) and asks for information about presenting problems, suicide/self harm, substance abuse, sexual abuse, exposure to trauma, mental health history, and legal issues. The clinician then determines the response priorities that are consistent with screening guidelines:

	Condition	Response
Screening/ Initial Contact	Individuals may request services by telephone or in person. Request also may be made by others, such as doctors, hospitals, schools, on behalf of the individual needing services	A secretary collects demographic information and a licensed mental health professional conducts screening using a screening guide.
Emergency Care	If dangerousness is indicated.	A qualified mental health professional responds to the individual within 30 minutes.
Urgent Care	If dangerousness is not indicated, but the individual's functioning is seriously impaired.	The individual receives a face-to-face intervention within a maximum of five (5) working days.
Non-Urgent Care	If symptoms reported are determined to be generally less intrusive and less serious although similar to those requiring urgent care.	The individual receives a face-to-face intervention within 15 working days of the screening/initial contact.

2. Adaptability for Replication

Pending the nature and services offered at the agency, screening process or protocols may vary. It is important to examine the screening process and protocols to ensure appropriate and timely responses.

F. Assessment and Treatment Planning

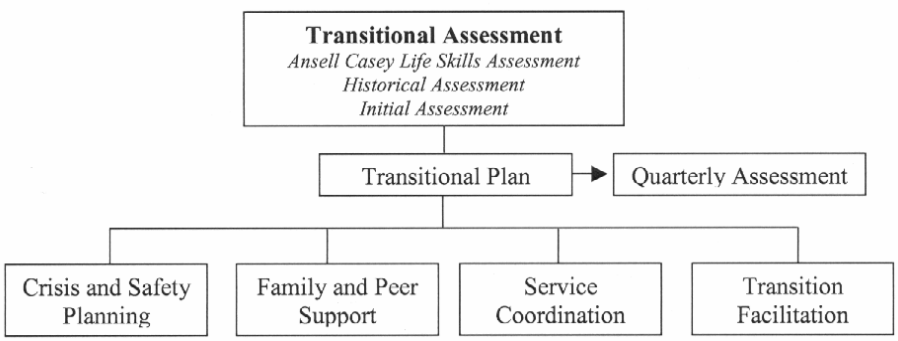
1. Overview of Project RECONNECT

In Project RECONNECT, each young person receives two (2) different sets of assessments: *clinical assessment* and *transitional assessment*. A licensed clinician conducts the clinical assessment, which examines presenting symptoms and psychiatric, social, and medical histories, before making psychiatric diagnoses. The diagnoses consider co-morbid conditions, atypical presentations, V codes, and deferred/provisional diagnoses. As illustrated in figures 3 and 4, the clinical assessment is the entry into the community mental health center and the basis for treatment planning, which authorizes types of mental health services to be provided.

The transitional facilitator conducts the specialized transitional assessment to determine the young person's needs. The assessment provides comprehensive information on the young person's history and current functioning in mental health, substance abuse, health, education, child welfare, disability, employment, and legal issues. It also documents the young person's and family's strengths, interests, characteristics, cultural traits, personal and familial values, and barriers to transition. The transitional assessment is the basis for a transitional plan that outlines transitional services. Sample transitional assessment is included in Appendix 11.

Project RECONNECT also uses the Ansell-Casey Life Skills Assessment (ACLSA) to assess young people's strengths and deficiencies in life skills. ACLSA is a case management tool and an instrument to evaluate young people's independent living skills. It consists of statements about life skills that the young people and their caregivers complete. All assessments and the scored reports are FREE of charge. The scores and responses in the report reflect young people's strengths, as well as, areas for growth. It is designed to help practitioners and caregivers create a life skills learning plan. This information is useful in goal planning and in starting discussions about life skills strengths and directions. The Life Skills Guidebook is FREE at the web site caseylifeskills.org and can be used with the Score Report to create a customized life-skills teaching plan. The assessment can be used for children, young people from 8 to 25 years old and has several versions for special populations; Spanish, French, Native American, pregnant teen, parenting of infants, and parenting young children.

Figure 12: Relationship of Transitional Assessment and Service Planning



2. Adaptability for Replication

Pending the nature and services offered at the agency/program, assessment and treatment planning process or protocols may be different. It is important to examine the process and protocols to ensure transitional assessment encompasses the transitional domains, is strength-based, and drives the treatment planning.

G. Engagement

1. Overview of Project RECONNECT

It is not uncommon for young people to experience anxiety and resistance, maybe even hostility, when being referred to the project due to the stigma issue and adolescent characteristics. Following are strategies used to engage and retain young people in the program:

- **a.** Individualized services that are based on young people's strengths, interests, potentials, cultural backgrounds, and familial values
- **b.** Active participation by young people, and their family, in the treatment planning, implementation, and evaluation
- **c.** Focus on skills development
- **d.** 24-7 crisis support, crisis/safety planning
- **e.** Open door policy. The open door policy acknowledges that a major task of young people is to explore self-determination and to experiment independent thinking. The entry and exit of the project should be flexible. Young people can return to the project after they choose to leave against staff recommendation, or if their functioning deteriorates after successful completion of the treatment.

2. Adaptability for Replication

Pending agency policy and procedures, it may not be possible to ensure open door policy. It is important to examine the policy and procedures to maximize the flexibility so young people and their families can self pace and self direct the treatment.

H. Transition Facilitation

1. Overview of Project RECONNECT

The core clinical element in Project RECONNECT is transition facilitation, the primary responsibility of transitional facilitators. Their services are a proactive form of case management. In addition to coordinating, linking, and monitoring services; transitional facilitators also function as coaches, mentors, and critics to assist the young people in learning functional and adaptative behaviors that are critical for transitioning into adulthood. In addition, they provide constructive and helpful feedback, model behaviors, convey an optimistic and positive outlook, and express encouraging and affirmative comments. (For more information on transitional facilitators' roles and functions, please refer to Chapter III, Section 5: Staff Role, Functions and Training requirements / recommendations.) Services provided by transitional facilitators do not replace core mental health services, such as therapy and medication. As youth continue in the project the intensity for these core mental health services may decrease due to the increased independence demonstrated by young people, and the improved treatment outcome achieved by transitional services.

Facilitators work with young people to develop transitional plans, coordinate services, and assist them in developing skills and competency. They also work with the youth's families, and other key stakeholders to develop transitional plans that are based on strength-focused needs assessments and address four transition domains (Clark, H.B., 2001, Revised):

- **a.** Education, including secondary and post-secondary education.
- **b.** Employment, including employment stability and career mobility.
- **c.** Living situation, including housing arrangement and stability.
- **d.** Community life adjustment, including skills and activities (community participation, daily living skills, family and peer support, and reduction in risk behaviors) that are essential to functioning in one's personal life and the community.

Changes outlined in the transitional plan should be orderly and sequentially arranged to foster optimal growth. Considering the dynamic nature of community settings and youth themselves, plans should be reviewed quarterly and modified if necessary to ensure its feasibility and appropriateness. Some services may be gradually tapered off as young people become more competent and independent.

The facilitator works with young people to establish an individualized **Transition Team** to help promote young people's transitional process. The Team consists of key players (service providers, community resources, families, and natural support) who can mobilize resources, services, and support. Any referral source should be included as a member that plays an integral part of the Transition Team because they have knowledge about the young people and their families. The referral source usually has a significant interest in the outcome of the services and strong commitment to the intervention. This makes the referral source an important partner in the transitional services. The goal of the Transition Team is that young people will gradually rely less on the facilitators and the formal support system (i.e., service providers)

and more on themselves and natural support system (e.g., families, peers) as they become more independent and self sufficient.

2. Adaptability for Replication

If a youth has an existing wraparound team that is providing wraparound services, that same team could ideally be utilized as a Transition Team. However, it is important to give them sufficient training to identify and understand their role in focusing on the transitional needs of the young person. This can also apply to youth in foster care who have existing family teams.

I. Service Coordination

1. Overview of Project RECONNECT

The service coordination approach employed by the project involves aggressive outreach, brokering of services, advocacy, follow-up, monitoring, progress review, service coordination, and community networking (Clark & Davis, 2000, & Stroul & Friedman, 1986). Services to be brokered include mental health, substance abuse, education, vocational training, employment, housing, health, legal assistance, and instrumental living skills, etc. Parenting training for teen parents, or prospective parents, should also be included. Facilitators often do not provide these services directly; however, they should have adequate working knowledge of these service systems to be an effective link between the young people and the systems.

Service coordination is to assist young people entering those aforementioned services without undue delay. Facilitators work with young people and providers to identify potential barriers to treatment and develop a plan to address barriers. It is important that facilitators are involved in the development of the service plans at those agencies, to ensure that those plans are consistent with the overall direction of the transitional plans. Facilitators also assist young people receiving services from the adult system, which often has limited experiences working with young adults. Facilitators should work closely with the adult system to ensure that the youth development focus is maintained and that the adult system has adequate understanding of the young people's developmental sufficiency and youth cultures.

a. Mental Health and Substance Abuse Services

To effectively coordinate mental health and substance abuse services, transitional facilitators need to have adequate knowledge of common evidence-based practices such as Cognitive Behavioral Therapy and Multisystemic Therapy. Facilitators should also be familiar with the mental health and substance abuse service system, including crisis services, outpatient, inpatient, day treatment, psychosocial rehabilitation, residential services, case management, and respite care. Co-occurring mental health and substance abuse disorders are no longer an exception, but rather an expectation for young people with emotional disorders. Facilitators need be very cognizant of such a possibility and pay special attention to treatment coordination and relapse prevention issues.

Transitional facilitators should carefully consider young people's life style and consider recommending parenting training. Sexuality and relationship are important issues for transitional youth and parenthood is a concern. Parenthood produces much stress, especially for people who are young and may lack the maturity for parenthood. Young people need the support, education, and skills to fulfill the responsibilities as parents.

b. Education

A challenge facing transitioning youth today is that schools identify disabilities based on conditions that hinder classroom learning, but do not address emotional difficulties. Currently schools are required to provide free and appropriate education to young people with disabilities, but the services provided are often focused only academic progress and do not address other key issues that help in transitional success. As a result the services to address the disability issues are is often inadequate or fragmented.

Project RECONNECT recognizes that education plays a critical role in a young person's life and actively works with schools to ensure that educational support is provided. Facilitators become active advocates for the youth and family in collaborating with schools to ensure that students' Individual Educational Plans **(IEP**), required under the Individuals with Disabilities Education Act **(IDEA**), are adequately developed and followed through. Facilitators also work with schools and young people to assist students to complete high school and enter employment, or post secondary education. Multiple and creative strategies are developed jointly with young people, families, schools and the community. They may include work-based learning to earn high school credits toward graduation, curriculum on life-skills building, peer counseling, on-campus mental health services, and specially developed core curriculum, etc. Examples of other important educational support services include tutoring, exposure to community experiences, personalized relationships, and mentorship (Cheney, Martin, & Rodriguez, 2000).

c. Vocational Training and Employment

Vocational training and employment services are often neglected for young people with SED. The lack of systemic vocational services produces high unemployment or underemployment. The post high school unemployment rate for young adults with SED exceeds 50% (Wagner, 1992). These types of issues impedes a young person's ability to achieve self sufficiency resulting in obtaining jobs with low wages, fewer hours and less benefits (Wagner, 1993).

The program collaborates with schools to improve early identification and assessment of young people with SED, so their transitional process can start early. While education professionals should be trained on issues facing young people with SED; the mental health professionals should also be educated about practices in Special Education and effective transition planning (Martrix Research Institute, 1998). Transitional facilitators work closely with schools and vocational rehabilitation to ensure that young people receive comprehensive services. These services should include: career education, vocational assessment, job survival skills training, vocational skills training, work experiences, place-

ment, and retention services. Many young people prefer a "place-then-train" setting where they have opportunities to serve an internship or obtain paid employment, simultaneously while training and supports are provided for job retention and advancement. Facilitators work closely with mental health, education, businesses and industries, and employment services to develop supported employment where these critical job support services are available in the least obtrusive way (Fitzgibbon, Cook, & Falcon, 2000, Stroul & Friedman, 1986 Revised).

d. Housing

Housing is critical issue in the transitional process. It needs to be available, suitable, affordable, and desirable to youth with appropriate levels of supervision and support. Realizing that the existing range of housing choices could be limited, facilitators must work with service providers and housing authorities to maximize housing options. When matching young people with housing options, facilitators assist young people to consider their preferences, needs for peer and family support, availability of community resources, levels of supervision and staff support, competency of community living skills, and young people's potential for high-risk behaviors. Basic rules and expectations need to be clearly established, such as visitors or upkeep of the property. Young people should experience the natural consequences that result from their own actions. Transition to new housing arrangements should be well planned and made gradually. It might take several moves before an appropriate housing option is identified. Housing arrangements should be reviewed regularly to foster independence (Platte, Kroner, & Ortiz, 2000).

e. Health

Many young people with emotional disorders also have other healthcare needs, including dental health, obesity, and diabetes, etc. It's important to coordinate with health care providers to ensure that young people reach optimal physical health. This also includes health education in nutrition, exercise, HIV/AIDS prevention, and sexual education, etc. When developing a healthcare plan, it is critical to consider young people's personal characteristics, risk profile, and environmental factors.

f. Legal Assistance

If young people are involved with the juvenile justice or adult criminal justice system, it is important for the facilitators to provide assistance so that the young person can become a productive and responsible citizen. It is very important for facilitators to maintain a therapeutic and recovery milieu that fosters independence and responsibility, while still conveying a sense of caring and empathy. It is also important for young person to experience natural and legal consequences without being rescued. For example, transitional facilitators may choose not to bail a young person out of the jail; but ensures that he/she will continue to receive needed support services like mental health care (e.g., medication) in jail.

g. Instrumental Living Skills

Young people with SED are often deficient in the area of instrumental living skills (e.g., food management, housekeeping, and money management, etc.) and interpersonal socialization. There may also be cultural issues to consider when considering developing instrumental living skills as cultures vary in social norms about values, beliefs, attitudes, and behavior. For example, a refugee youth from a different social and religious background may be unfamiliar with social norms of their new home. This would result in special assistance for that young person to understand what is deemed acceptable and appropriate in this culture. Facilitators are coaches, mentors, and practice partners who actively assist youth in gaining these instrumental living skills. It is important to expand the learning beyond the formal classroom format, and facilitators should identify or create opportunities for youth to practice learned skills in community settings. In that context these newly acquired skills can become relevant and meaningful. (Clark & Davis, 2000).

Project RECONNECT uses the Ansell-Casey Life Skills Assessment (ACLSA) to assess young people's strengths and deficiencies in life skills. The information is FREE at the web site http://www.caseylifeskills.org . The assessment can be used for children, young people from 8 to 25 years old and has several versions for special populations; Spanish, French, Native American, pregnant teen, parenting of infants, and parenting young children.

2. Adaptability for Replication

Pending agency policy, procedures, and funding steams; it may not be possible to provide comprehensive service coordination in all identified areas. It is an important factor is the commitment to examine and assess the policies and procedures of the project on a frequent basis to modify and improve the project. Simultaneously commitment and attention should be given to examine funding streams to maximize service coordination by the facilitators.

J. Family and Peer Support

1. Overview of Project RECONNECT

Family support is maximized through early involvement and continued participation in the transitioning process. Considering the dynamics of a young person's life experiences, families are recognized as the defined units where primary care is given. Family units and how they are defined vary from the traditional recognized family structures (biological, adoptive, or foster families) to living with relatives or living with a friend's family. Facilitators may also examine different cultural perspectives about family units to acknowledge and respect the differences. As a young person experiences transitioning, families also experience their own transition. If families do not adjust to the changes of the young people, communication and relationship between the two may break down. Facilitators assist families to adjust from being protectors and providers to being a source of support for the young person. The family stays involved and informed in the young person's life, while balancing the young person's rights to privacy. Early in the transition, the issue of confidentiality should be addressed so

all involved have a clear understanding and agreement. (Hatter, Williford, & Dickens, 2000). Cultural values impact how family and peer supports should be developed appropriately.

While the family takes on the changing roles in the young person's life, their peers also are affected by the transition. Peers become increasingly important and influential. Facilitators assist the young person in identifying and developing positive peer support while encouraging them to participate in youth oriented programs such as peer support groups, recreational opportunities and leadership activities. The ultimate goal is for the young person to obtain knowledge and skills to surround themselves with positive peer support.

Project RECONNECT holds an annual overnight retreat for program participants to provide leadership and socialization opportunities. Young people develop the agenda and plan the logistics with assistance from transitional facilitators. Facilitators need to closely monitor and supervise all youth-run activities to ensure their appropriateness and to minimize any potential liabilities.

2. Adaptability for Replication

There are family and consumer advocacy groups in every state which are excellent resources for family and youth support. These may include local organizations or chapters of: the Federation of Families for Children's Mental Health or the National Alliance on Mental Illness, etc. Often organization like this have specific youth focused programming that is beneficial for transition youth.

K. Crisis and Safety Planning

1. Overview of Project RECONNECT

Transition is a time period when young people begin to experience independence. It is also a time to understand that they may make mistakes and that crisis situations can occur. It is important for the young person, their families, and service providers to view a crisis as something that can be managed proactively. One can often predict and prevent crisis, however, crisis does happen and it does not mean treatment failure. Safety plans and crisis plans are different. All treatment plans have a crisis plan to addresses risk reduction as a treatment goal. The safety plans exist when a tangible safety risk to the young person, family, or community is present.

Safety planning is an integral part of the transitional plan. It should include the following:

- **a.** Describe situation/need for the safety plan
- **b.** Describe safety precautions
- **c.** Identify rules and/or self-management coping strategies
- **d.** Identify entities to be involved and educated about the safety plan
- **e.** Describe therapeutic intervention/action plan, including teaching skills
- **f.** Identify conditions for hospitalization/incarceration/crisis placement

g. Client, family members, and other key players participated in the development of the plan, agree to the plan, and all parties have a copy of the plan
h. Plan is signed and dated

A good safety plan has the following characteristics:

a. Includes as many proactive and preventative strategies as possible
b. Communicate with others
c. Builds upon the young people's strengths and natural support network
d. Examine strategies to minimize possible secondary gains for the young people
e. Teach skills to provide replacement behaviors to access more appropriate social and non-social reinforcers
f. Teach Coping Skills
g. Recognition of one's triggers (internal or external)
h. Teach alternative responses
i. Stress management
j. Avoidance of high-risk situations
k. Self-imposed respite or escape responses
l. Safety precautions, e.g., removing means of doing self harm
m. Increase support and/or teach increased utilization of necessary support
n. Identify conditions under which the following types of intervention would be utilized: emergency medical unit, police, hospitalization, medication review, crisis unit, etc.
o. Identify types of interventions that <u>should not</u> occur: e.g., removal from school, work, or home; forced medication; and out-of-home placement if alternatives are available.
p. Build a plan with appropriate "triage" responses based on the level of crisis intensity and severity
q. Make sure all participants, including young people, have a copy of plan and are clear about their roles.
r. Review and update plan on regular basis or as needed.

2. Adaptability for Replication

Crisis and safety planning is an integral part of treatment planning. Such plans should be developed even for young people who are in secured settings, e.g., residential program or in patient facility.

VI. Recommendations for Promoting Change in Mental Health Care Settings

For agencies that plan to implement transitional services, they are advised to examine possible barriers in system and clinical components to develop solutions that will streamline the process. The following are some of the system and clinical barriers experienced by Project RECONNECT. The following problems were addressed in our project. The response to each of these issues is written in *italics*.

A. System Issues

1. Agency Policy and Operating Procedures

Many community mental health centers in the country traditionally tailor their services for Medicaid eligible clients, including youth in state custody. Homeless youth, children with disabilities, sexual minorities, non-Medicaid, ethnic/racial minorities, refugees, deaf/hearing impaired, and youth who are parents are often underserved.

The public mental health system needs to improve its service access for the populations that are traditionally underserved. It is critical to develop linkages with these groups by inviting their participation on the State Steering Committee and Local Advisory Council. The demographic data collected by service providers should include the aforementioned special characteristics so access by these populations can be monitored. Facilitators should assist young people to access funding such as Medicaid.

2. Lack of Coordination between Adult and Child Mental Health System

Traditionally, adult and child mental health systems operate under different philosophies and procedures. The children's system orients itself toward strength-based youth development, System of Care models, and values family involvement. Most of these concepts are not well integrated into the adult system. The adult system also may have more rigid eligibility requirements. For example, some mental health centers in Utah do not serve sex offenders or people with mental retardation in the adult system, while these two groups are eligible for services in the children's system.

Cross training is necessary to improve the collaboration between adult and child mental health services. Mental health centers are encouraged to examine the feasibility of system integration by creating a "Transitional Unit" to serve transitional youth.

3. Varying System Capacity to Implement TIP Model

Agencies are at different readiness level to implement the TIP model due to their varying availability of resources, local infrastructure, and community awareness. The level of readiness affects the implementation schedule.

It is critical to allow sufficient time to conduct strategic planning so the community and the agency reach optimal level of readiness. However, the agency does not need to wait until all system components (Interagency and intra-agency, community development, family development, youth development and cultural competency) are well in place to start the implementation of the transitional services. It is appropriate to gradually implement the clinical components of the TIP system, while enhancing the system components.

4. Community's Lack of Understanding and Commitment to the Planning Process

Communities are often eager to start implementing services and may see strategic planning as burdensome, or unnecessary. In addition, agencies may feel unsettled about the strategic plan because it requires them to adopt new philosophies, attitudes, and practices to meet the needs of the youth, families, and the community.

The strategic planning process should be mandated and the membership of the State Steering Committee or the Local Advisory Council should be monitored to ensure that they are inclusive of key stakeholders in the community. Often, the community soon discovers the power of strategic planning and will faithfully carry it out.

5. Bundling of Services

Many mental health centers have policies to provide case management services in conjunction with the core clinical mental health services, such as individual therapy and medication management. Sometimes this policy presents a barrier for privately insured youth and families who are required to go to the insurance network for core mental health services. Under the restriction of service bundling, they cannot access case management and transitional services from the mental health centers.

Mental health centers should examine their policies and make revisions to allow young people and their families with private insurance to receive transition facilitation service; even if they receive other mental health services from a different provider.

B. Clinical Issues

1. Individualized Services

One challenge is to ensure that services are individualized to meet each young person's needs and readiness level. Some mental health centers provide services following established program guidelines or curriculums/treatment modalities. For example: a living skills development class that utilizes a set curriculum that is not easily modified. This type of service may not meet the needs and readiness level of the individual young person and their families.

The project staff should closely monitor the service design, and provides technical assistance to ensure that the design adheres to the principle of individualized care.

2. Communication Mode

Many young people do not have access to phones and it is a challenge to maintain good and regular communication between facilitators and young people.

Facilitators should have cell phones and program participants are provided with phone cards.

3. Care Coordination with Private Providers

Care coordination becomes more challenging when a young person receives services from multiple entities. For example, a young person receives medication from a private provider while receiving transitional services from Project RECONNECT. This young person's ability to participate in, and benefit from, Project RECONNECT may depend on his/her response to medication.

Each provider has to be diligent in informing others about treatment progress and changes so treatment can be seamlessly coordinated. It is critical that transitional facilitators maintain regular communication with other providers so care can be coordinated to fit the young person's level of functioning.

4. Supervision for Transitional Facilitators

Transitional facilitators are certified case managers with responsibilities to coordinate transitional services. The scope of their practices is limited to care management and advocacy. One challenge faced by transitional facilitators is the regular and immediate access to supervision since they are often out in the field seeing clients. Facilitators have frequent contacts with the young people and their families. They may learn about information that will impact clinical treatment before therapists learn about it.

It is critical that facilitators understand their scope of practice and seek supervision timely when situations arise. It is also critical for mental health centers to develop a mechanism that allows facilitators to have immediate access to supervision no matter when and where they are.

VII. Elements to Help Program Leaders to Maintain and Extend the Gains

A. Fidelity scales and Process Indicators

The implementation of Project RECONNECT with fidelity should be monitored at three levels: ***administrative***, ***system*** and ***clinical*** (see Appendix 12). The outcome will be measured by records review, interviews, and surveys.

1. Administrative Fidelity

Administrative Elements			
Elements	**Seq. #**	**Summative Statement**	**Methods***
Eligibility	A1	Young people who are between the ages of 14 and 21 may be admitted into the program, but once admitted, they may continue in the program through age 25.	P/P.R. R.R.
	A2	Young people who are diagnosed with serious emotional disturbances (SED) in childhood or with newly emerging serious mental illness (SMI).	P/P.R. R.R.

Administrative Elements			
Elements	**Seq. #**	**Summative Statement**	**Methods***
Collaboration w/ Non-MH Providers	A3	There is a mechanism for collaboration with key partners in the areas of employment, living situation, education, community life and other partners such as Indian tribes, state and local public agencies in child welfare, juvenile justice, and disability issue.	P/P.R. O.A.
Management	A4	Transitional service is illustrated in the organizational chart.	O.A.
	A5	The agency staff, including administrators, supervisors, co-workers (clinicians and case managers), and transitional facilitators undergo appropriate training and orientations	P/P.R.
	A6	The roles and functions of administrators, supervisors, co-workers, and transitional facilitators are well defined and assigned to appropriate staff so all transition-relevant functions are carried out with fidelity.	P/P.R. O.A.
	A7	The mechanism for supervision and consultation ensures professional growth and accountability by facilitators.	P/P.R. O.A.
	A8	Facilitators have access to work space including meeting rooms that ensure confidentiality.	
	A9	Facilitators have access to adequate technologies and equipments to perform duties at job site and in the field.	O.A.
Caseload	A10	The caseload size allows the facilitator to provide adequate attention and support to young people and that young people receive adequate individualized services. It takes into account the characteristics of cases and the facilitator's limitations.	R.R.
Flexible Funds	A11	Program budget shows flexible funds as dedicated funds for program participants.	F.R.
	A12	There is a clear mechanism to approve and disburse flexible funds	P/P.R.
Program Costs	A13	Program cost adheres to the financing guidelines.	F.R.

2. System Fidelity

System Elements			
Elements	**Seq. #**	**Summative Statement**	**Methods***
Intra-Agency Collaboration	S1	There are clear policy and procedures that allow easy and gradual transitioning of young people from children/youth system to the adult system within the agency.	P/P.R. O.A.
	S2	There is a mechanism for cross training for children/youth and adult systems within the agency.	P/P.R. O.A.
	S3	Cross staffing occurs for all transitioning youth cases.	P/P.R. R.R.
Community Development	S4	Steering Committee membership is inclusive; its roles and functions are well defined, including project oversight and community mobilization. The Committee meets regularly.	Roster and meeting minutes
	S5	If appropriate, local Advisory Councils and workgroups are organized and meet regularly.	Roster and meeting minutes
Family Development	S6	The Family Council's roles and functions are well defined with a strong family focus. The Council meets regularly.	Roster and meeting minutes
	S7	Family Council members receive leadership training.	Training Log
	S8	Every family member is provided with the opportunity to attend the Family Orientation.	P/P.R. R.R.
Youth Develop-ment	S9	The Youth Council's roles and functions are well defined with a strong youth focus. The Council meets regularly.	Roster and meeting minutes
	S10	Youth Council members receive leadership training.	Training Log
Cultural Competence	S11	Cultural Competency Advisory Council membership represents the diversity of the community; its roles and functions are well defined with a strong cultural competency focus. The Council meets regularly.	Roster and meeting minutes
	S12	Staff receives training on the Cultural Competency Practice Model and cultural diversity.	Training Log
	S13	Cultural Consultant Resource Bank is organized.	P/P.R.

3. Clinical Fidelity

Clinical Elements			
Elements	**Seq. #**	**Summative Statement**	**Methods***
Principles of The Practice	C1	The Project adheres to the seven guiding principles.	P/P.R. R.R.
Pathway Into Care	C2	The Project has a clear pathway into care diagram that illustrate sequential steps.	P/P.R.
Social Marketing and Outreach	C3	The Project has a clear social marketing and outreach plan to increase the community's knowledge and awareness of the Project.	Product Review
Referral	C4	The Project has a mechanism to track the referral sources and responses.	R.R.
Screening	C5	The Project has a clear process to screening young people for their appropriateness for the Project.	P/P. R.
Assessment and Treatment Planning	C6	Each young person receives clinical assessment and transitional assessment conducted by appropriately licensed professionals.	R.R.
	C7	Transitional assessment and planning is comprehensive, individualized and strength-based.	R.R.
Engagement	C8	The Project has a clear method to retain young people and their families' engagement in the Project.	R.R.
Transition Facilitation	C9	The facilitator provides transition facilitation in four domains –education, employment, living situation and community life adjustment – in an orderly and sequential manner.	R.R.
	C10	Each young person has a Transitional Team to assist in his/her transitioning process.	R.R.
Service Coordination	C11	The transitional facilitator provides case management and service coordination across mental health, substance abuse, education, vocational training, employment, housing, health, legal assistance, and instrumental living skills, as well as the adult system	R.R.
Family and Peer Support	C12	Developing and maintaining family and peer support are an integral part of the transitional services.	R.R.
Crisis and Safety Planning	C13	Every young person has a crisis plan that addresses risk reduction. Young person also will have a safety plan if there is a tangible safety risk to self, home and community.	R.R.

* P.P.R: Policy/Procedure Review
R.R.: Records Review
O.A.: Organizational Assessment
F.R.: Finance Review

B. Outcome Measures and Evaluation Design

The main outcome measure is the Ansell-Casey Life Skills Assessment (ACLSA), which assesses young people's strengths, deficiencies and improvement in life skills. It is web-based and FREE of charge from the Ansell-Casey Foundation. The ACLSA is administered at the time of intake, every six months and at the time of discharge from the program. The Ansell Casey Life Skills Assessment can be accessed from http://www.caseylifeskills.org .

C. Client Satisfaction

Project RECONNECT annually conducts a survey that documents youth and family satisfaction with the program. This is a standardized survey developed by Mental Health Statistics Improvement Program (MHSIP) to evaluate participant satisfaction (see Appendix 13).

D. Quality Improvement

A well-designed Continuous Quality Improvement (CQI) process ensures that the project design is regularly examined and improved upon. This process of quality improvement holds the project accountable to key stakeholders, by identifying deficiencies and overcoming barriers. With Project RECONNECT, CQI takes place externally and internally.

Externally, Project RECONNECT solicits input from advisory groups and the community regarding the outcome of the project:

1. Program Advisory Structure: The Steering Committee, Local Advisory Council, Family Council, Youth Council and Cultural Competency Advisory Council review evaluation reports, assist in interpreting outcome data, identifying program strengths and deficiencies, and developing solutions.

2. Focus Groups and Key Informant Interviews: Focus groups and key informant interviews are conducted to solicit feedback from community key stakeholders about the program. Community key stakeholders include young people, families, advocates, referral sources, agencies/organizations relevant to transitional services and funding sources, etc.

Internally, Project RECONNECT monitors and improves the quality of services through supervision, training, and records review. Facilitators have regular supervision, both individually and in groups, to discuss implementation issues and to problem solve. Regular training and technical assistance are provided to build the agency's and staff's capacity in implementing the transitional services. The Division of Substance Abuse and Mental Health conducts annual site visits to the community mental health centers to review administrative structure, policy and procedure, and clinical records.

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Appendix 1

Supportive Research Finding

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

1. Engage young people through relationship development, person-centered planning, and a focus on their futures

Guideline Element	Empirical Support	Professional Consensus
A Use a strength-based approach with young people, their families, and other informal and formal key players.	1. Armstrong, Dedrick & Greenbaum (2003); Study focus: 7-yr longitudinal study	1. Pollard et al. (2003) Discusses an integrated model of a positive strengths-based and problem-focused approach to child well-being
B Build relationships and respect young persons' relationships with family members and other informal and formal key players	1. Linnehan (2003); Study focus: Longitudinal design examining a formal work-based mentoring program & informal mentoring work relationships	1. Forehand & Kotchick (2002): Discusses behavioral parent training & factors that affect its implementation
C Facilitate personal-futures planning and goal setting	1. Benz, Lindstrom & Yovanoff (2000); Study focus: Reports findings from 2 studies of secondary & transition practices	1. Bullis & Cheney (1999) Personal futures planning cited as a component of suggested model programs
D Include prevention planning for high-risk situations, as necessary	1. Schinke, Cole & Poulin (2002); Study focus: Econ. disadvantaged early adolescents receiving educational enhancements were compared to controls	1. Dembo & Walters (2003) Discusses innovative approaches to identifying and responding to the needs of high risk youth

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

1. Engage young people through relationship development, person-centered planning, and a focus on their futures

Guideline Element	Empirical Support	Professional Consensus
E Engage young people in positive activities of interest	1. Bullis & Yovanoff (2004); Study focus: Interviews of formerly incarcerated youth 2. Bullis et al. (2002); Study focus: 5-yr longitudinal study 3. Benz et al. (1997); Study focus: Re-examination of a 2-state, follow-along data set 4. Cawley et al. (2002); Study focus: Demonstration project	1. Fiske (1998) Discusses service-learning as a strategy for engaging students in active learning 2. Redd (2002) Review of 300+ studies on educational adjustment, achievement, and attainment. Key findings include engagement 3. Staudt (2003): Critically reviews studies of engagement interventions for children & their families
F Respect cultural and familial values and young persons' perspectives	1. Causey, Kelly (2002); Study focus: 32 in-depth interviews yielded youth's perceptions, experiences, & sources of info.	1. Cartledge, Kea & Simmons-Reed (2002) Present the need for culturally competent practitioners in the area of SED 2. Obiakor & Wilder (2004) Discusses ethnically diverse learners with emotional or behavioral disorders

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

2. Tailor services and supports to be accessible, coordinated, developmentally-appropriate, & build on strengths to enable the young people to pursue their goals across all transition domains

Guideline Element	Empirical Support	Professional Consensus
A Facilitate young persons' goal achievement across all transition domains: • Employment and Career • Educational Opportunities • Living Situation • Community Life Functioning	1. Radosevich, Vaidyanathan, Yeo & Radosevich (2004); Study focus: longitudinal field study 2. Cook, Solomon, Farrell, & Koziel (1997); Study focus: Vocational initiatives 3. Clark, Pschorr, Wells, Curtis, & Tighe, T. (2004). Study focus: Collaborative systems and program outcomes	1. Mortimer, Zimmer-Gembeck & Holmes (2002) Discusses qualitative interviews from the Youth Dev. Study & yields themes characterizing decision making about schooling & occupational careers of youth in transition 2. Griffith & Graham (2004) Discusses specific strategies & effects of goal-setting
B Tailor services and supports to be developmentally-appropriate and build on the strengths, and address the needs, of the young people, their families, and other informal key players	1. Scanlon & Mellard (2002) Study focus: retrospective cohort 2. Feldman & Werner (2002); Study focus: Survey comparing the effects of Behavioral Parent Training; Control group used.	1. Johnson et al. (2002) Meta-analysis; discusses specific strategies & recommendations

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

2. Tailor services and supports to be accessible, coordinated, developmentally-appropriate, & build on strengths to enable the young people to pursue their goals across all transition domains		
Guideline Element	**Empirical Support**	**Professional Consensus**
C Ensure that services and supports are accessible and coordinated	1. Certo et al. (2003) Study focus: Utilizes & Discusses implementation data from Transition Service Integration Model 2. Bullis & Yovanoff (2004); Study focus: Interviews of formerly incarcerated youth	1. Buysse, Sparkman & Wesley (2003) Examines the community of practice model as a framework for integrating ed. research & practice 2. Lehman, Clark, Bullis, Rinkin, & Castellanos (2002) Coordination of multiple systems pertaining to ED is presented 3. Hodges, Hernandez & Nesman (2003) Discusses collaborative development 4. Mellard & Lancaster (2003) Discusses interagency linkages between school personnel and community agencies
D Balance the transition facilitators' role with that of the young people, their parents, and other informal and formal key players	1. Geenen, Powers & Sells (2003) Study focus: Surveyed adolescents to assess provider's responsibility to assist in transition activities	

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

3. Acknowledge and develop personal choice and social responsibility with young people

Guideline Element	Empirical Support	Professional Consensus
A Encourage problem-solving methods, decision making, and evaluation of impact on self and others	1. Pinquart, Juang, & Silbereisen (2003) Study focus: longitudinal study 2. Causey, Kelly (2002); Study focus: 32 in-depth interviews yielded youth's perceptions, experiences, & sources of info.	1. Mortimer, Zimmer-Gembeck, Holmes, & Shanahan (2002); Investigates the themes characterizing decision making about schooling and occupational careers from the Youth Development Study
B Balance one's work with young people between two axioms: • Maximize the likelihood of the success of young people • Allow young people to contact natural consequences through life experience	1. Creed, Muller & Patton (2003); Study focus: Surveys pre- & Post- high school 2. West, Targett, Steininger, & Anglin (2001); Study focus: Quality assurance & employment data from the Project Corporate Support (CORPS): A model demonstration project on workplace supports	1. Kohler & Field (2003); Describes effective transition practices in five areas: student-focused planning, student development, interagency collaboration, family involvement, and program structures 2. Phillips, David, & Jobin-Davis, et al. (2002) Identifies factors that facilitate readiness for the transition from high school to work

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

4. Ensure a safety-net of support by involving a young person's parents, family members, and other informal and formal key players

Guideline Element	Empirical Support	Professional Consensus
A Involve parents, family members, and other informal and formal key players	1. West, Targett, Steininger, & Anglin (2001); Study focus: Quality assurance & employment data from the Project Corporate Support (CORPS): A model demonstration project on workplace supports	1. Burns & Goldman (1999); Meta analysis; Discusses Wraparound
B Parents, family members, or other informal key players may need assistance in understanding this transition period or may need services/supports for themselves	1. Feldman & Werner (2002); Study focus: Survey comparing the effects of Behavioral Parent Training; Control group used.	1. Forehand & Kotchick (2002); Discusses Behavioral Parent Training
C Assist in mediating differences in the perspectives of young people, parents, and other informal and formal key players	1. Cooney (2002); Study focus: Qualitative research methods	1. Lohrmann-O'Rourke& Gomez (2001); Discusses systematic preference assessment within transition planning as a way to accurately interpret the preferences of students who use limited symbolic or nonsymbolic communication

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

4. Ensure a safety-net of support by involving a young person's parents, family members, and other informal and formal key players

Guideline Element	Empirical Support	Professional Consensus
D Facilitate an unconditional commitment to the young person among his/her key players	1. Cohen-Scali (2003); Study focus: examines the role of social & professional experiences by 1,000 young adults (aged 16 to 18 yrs old) in order to construct their Professional Identity	1. Scott, Nelson, Liaupsin et al. (2002); Discusses Positive Behavior Support (PBS) as a linkage of resources & service providers for effective prevention & intervention efforts
E Create an atmosphere of hopefulness, fun, and a future focus	1. Stacey, Wendy (2002); Study focus: Interviews investigating mitigating stress prior to entering the work force	

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence

Guideline Element	Empirical Support	Professional Consensus
A Utilize assessment methods, e.g., functional in-situation assessment	1. Mueller, Edwards, & Trahant (2003) Study focus: Evaluated functional analysis outcomes 2. Karpur, Clark, Caproni,, & Sterner (2005); follow-up study of student exiters form a transition program	1. Holmes (2004); Discusses abstract functional analysis in theory construction 2. Scott, Bucalos, Liaupsin, et al. (2004); Discusses functional behavior assessments (FBAs) when developing intervention plans for students with disabilities
B Teach meaningful skills relevant to the young people across transition domains	1. MacAllum, McDonald, & Johnson (2002); Study focus: Program evaluation Of the Lansing Area Mfg. Partnership	1. Luecking & Gramlich (2003); Discusses work-based learning & its benefits

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence

Guideline Element	Empirical Support	Professional Consensus
C Use teaching strategies in community settings	1. Wilmshurst (2002); Study focus: Youth with severe emotional & behavioral disorders (EBD) were randomly assigned for 3 mo of intensive treatment to a 5-day residential program (5DR Program) or a community-based alternative, family preservation program (FP Program)	1. Lehman, Clark, Bullis, Rinkin, & Castellanos (2002) Coordination of multiple systems pertaining to ED is presented
D Develop skills related to self-management, problem-solving, self-advocacy, and self-evaluation of the impact of one's choices and actions on self and others	1. Martin, Mithaug, Cox et al. (2003); Study focus: Pre- and postassessment of secondary-age students' use of self-determination contracts to regulate the correspondence between their plans, work, self-evaluations, & adjustments on academic tasks	1. Field, Sarver, & Shaw (2003); Discusses Self-Determination in postsecondary programs for students with disabilities, including those with learning Disabilities 2. Wehmeyer, Field, Doren, Jones, & Mason (2004); Meta analysis on self-determination 3. Vuchinich & Tucker, (1998); Discusses the perspective of competing motivations 4. Rollnick & Miller (2001); discusses motivational interviewing

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

6. Maintain an outcome focus in the TIP system at the young person, program, and community levels

Guideline Element	Empirical Support	Professional Consensus
A Focus on a young person's goals and the tracking of his/her progress **B** Evaluate the responsiveness and effectiveness of the TIP system **C** Use process measures for continuous TIP system improvement	A through C 1. Bullis & Fredericks (2002) Study focus: Evaluates vocational and transition services for adolescents with EBD 2. Bullis, Morgan, Benz, Todis, & Johnson (2002); Study focus: Description and evaluation of the ARIES Project: Achieving Rehabilitation, Individualized Education, and Employment Success for Adolescents with EBD 3. Karpur, Clark, Caproni,, & Sterner (2005); follow-up study of student exiters form a transition program 4. Cheney, Hagner, Malloy, Cormier, & Bernstein (1998); Study focus: Analysis of the initial results of Project RENEW 5. Cook, Solomon, Farrell, & Koziel (1997); Study focus: Vocational initiatives 6. Clark, Pschorr, Wells, Curtis, & Tighe (2004); Study focus: evaluates collaborative systems and program outcomes for youth with EBD transitioning into community roles	A 1. Bullis & Fredericks (2002) B 1. Bullis (2002); Reviews how to conduct longitudinal data collection in a transition system C 1. Kohler & Hood (2000); Discusses 20 innovating approaches to addressing the needs of students with disabilities. Programs were selected based on a nomination process with specific criteria which addressed best practices which lead to positive ed., employment and indep. living outcomes for youth with disabilities

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels

Guideline Element	Empirical Support	Professional Consensus
A Maximize the involvement of young people, family members, informal and formal key players, and other community representatives	1. Lehman, Clark, Bullis, Rinkin, & Castellanos (2002) Study focus: Coordination of multiple systems pertaining to ED is presented 2. Thompson & Kelly-Vance (2001); Study focus: Examines the impact of mentoring on the academic achievement of at-risk youth involved in a Big Brothers/Big Sisters program	1. Benz (2002); expert opinion of how to overcome barriers & issues which occur during a community-school collab. 2. Tilson, Luecking & West (1996); examines the roles employers play in the school-to-work transition of youth with disabilities
B Tap the talents of peers and mentors: • Hire young adults as peer mentors and peer counselors • Assist young people in creating peer support groups • Use paid and unpaid mentors (e.g., coworker mentors, college mentors, apartment roommate mentors)	1. Linnehan (2003); Study focus: Longitudinal design examining a formal work-based mentoring program & informal mentoring work relationships 2. Granucci, Westerlund, & Clark (2003); Study focus: Experimental analysis of coworker mentors effects on the job performance of young people 3. Wagner & Clark (2004); Study focus: Experimental analysis of coworker mentors use of goal setting procedures with young adults in the work place	1. Linnehan (2003); explored the relation of urban high school student attitudes toward school, work, and self-esteem beliefs to work-based mentoring, mentor satisfaction, and employment status. Participants included high school students taking part in a formal work-based mentoring program, students who established informal mentoring relationships at work, students who worked without a mentor, and students who were not employed during the academic year.

Table 1: TIP System Guidelines and Practice Elements with Associated Empirical Research Findings or Professional Consensus

7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels

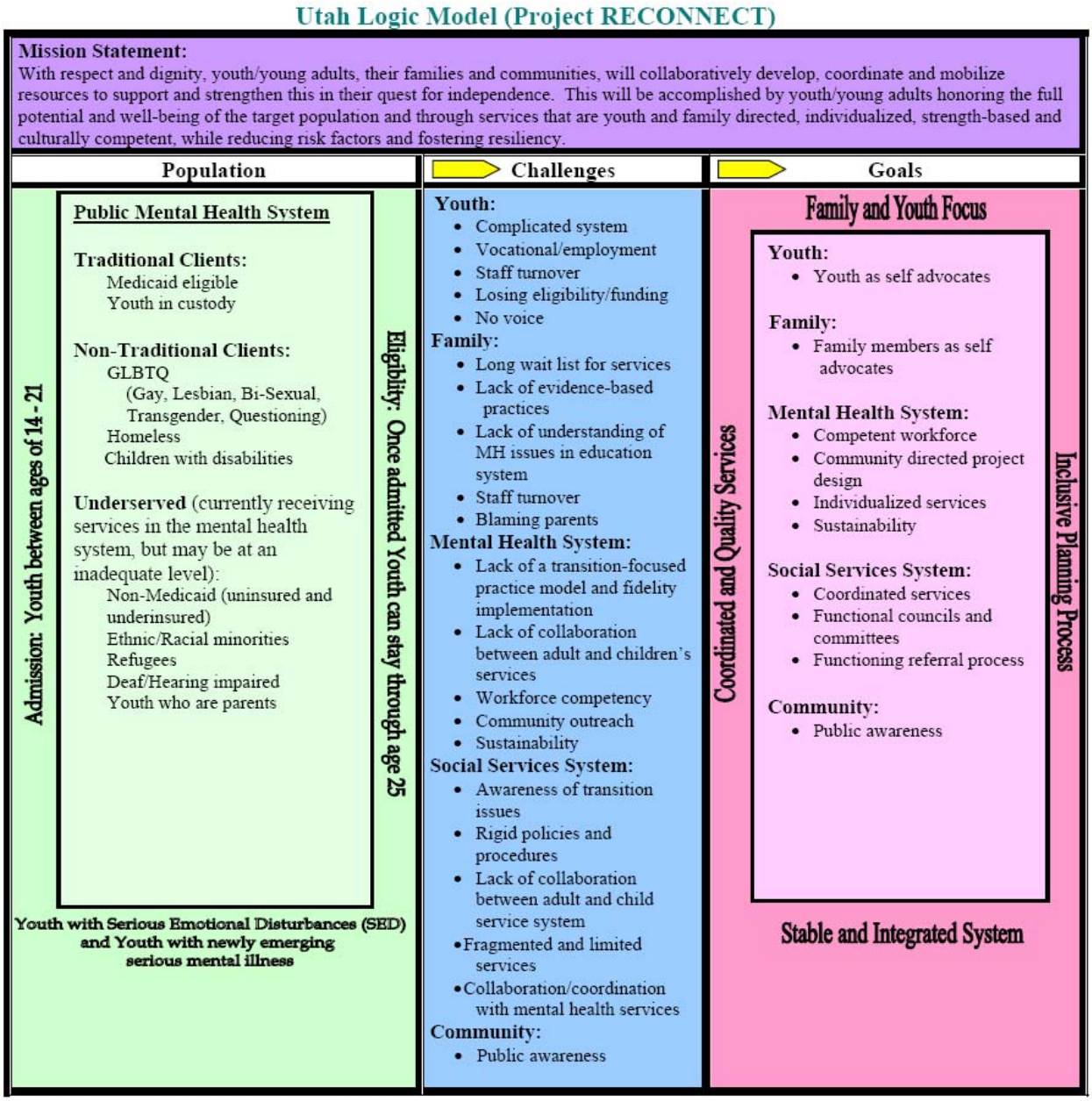
Guideline Element	Empirical Support	Professional Consensus
C Partner with young people, parents, and others in the TIP system governance and stewardship	1. Burns & Goldman (1999); Study focus: Meta analysis; discusses wraparound	1. Lehman, Clark, Bullis, Rinkin, Castellanos (2002; Describes the evolution of transition services for youth with disabilities from a systems-driven to a youth-centered support approach
D Advocate for system development, expansion, and evaluation -- and for reform of funding and policy to support a responsive, effective service system for young people in transition and their families		1. Adelman & Taylor (2000); Argues for a comprehensive, multifaceted continuum of school-community interventions to address barriers to student learning & promote healthy development

FILE: Research TIP Empirical
6-3-05

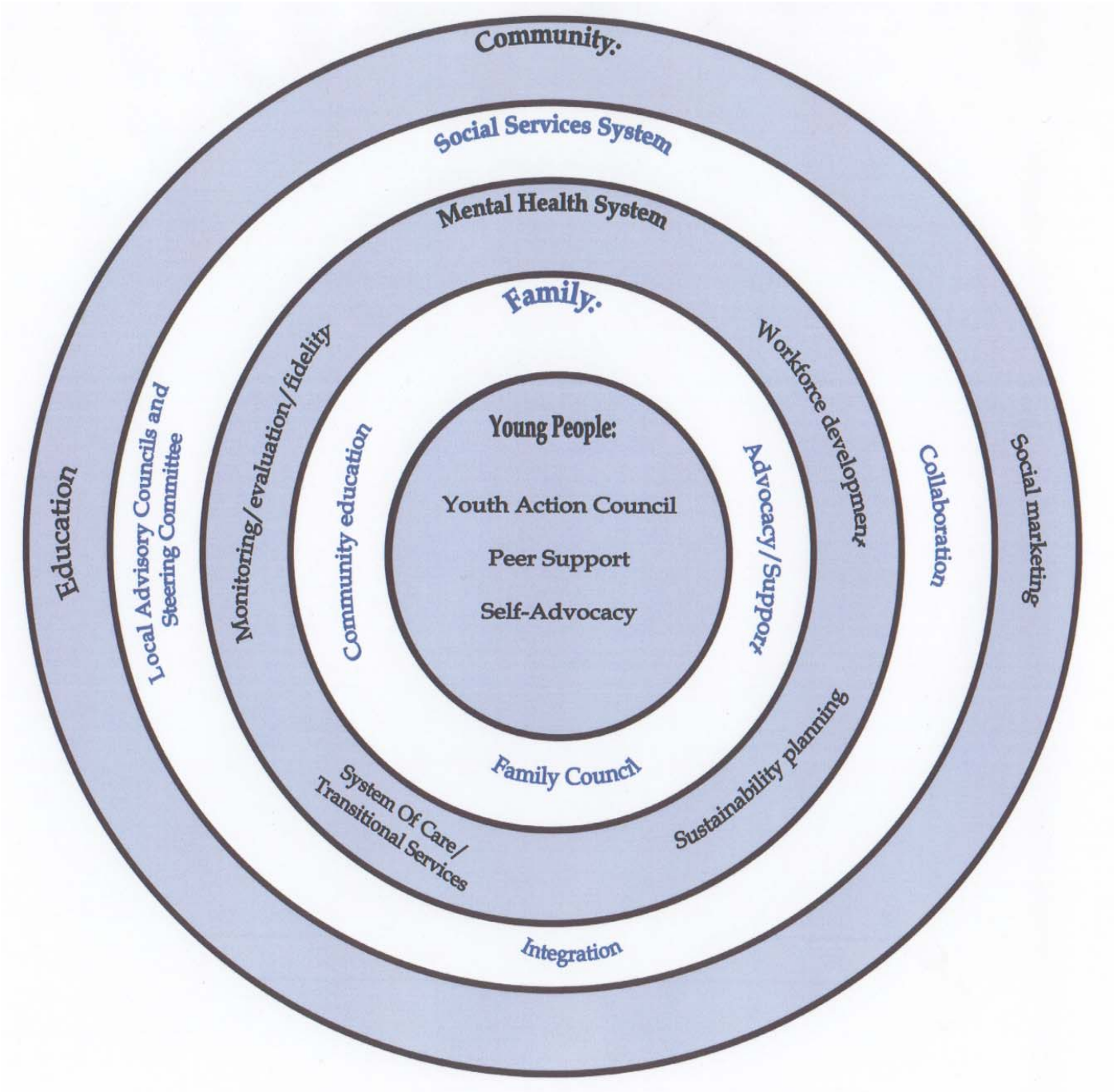
Appendix 2

Logic Model

Utah Logic Model – Population, Challenges and Goals



Utah Logic Model – Strategies



Appendix 3

Sample Contractual Scope of Work

1. **PURPOSE AND SCOPE OF CONTRACT**: The Contractor will coordinate with the Project RECONNECT (*Responsibilities, Enhancement, Competency, Opportunities, Networking, Neighborhood, Empowerment, Collaboration, and Transition*) in a strategic planning process to develop, implement, document and sustain elements of a model comprehensive program, with a strong mental health component, for youth transition to adulthood. The program will be implemented in four (4) community mental health centers (CMHC).

   The Contractor will provide transition facilitation services to a limited group of qualifying youth to test the pilot treatment services.

PART II: SCOPE OF WORK AND SPECIAL CONDITIONS

3. **DESCRIPTION OF THE SERVICES OR SUPPORTS TO BE PROVIDED UNDER THIS CONTRACT.**

General Description:

The overall objective is to mobilize and coordinate community resources to implement a comprehensive, community-based youth transition service model that has strong mental health component for DHS/DSAMH/Project RECONNECT (Responsibilities, Enhancement, Competency, Opportunities, Networking, Neighborhood, Empowerment, Collaboration and Transition) Contractor agrees to coordinate with the development, implementation, document and sustain elements of a model comprehensive program for youth transition to adulthood. Contractor agrees to comply with direction from national and state partners regarding model development, evaluation, site visits, and acceptance of technical assistance. The program will be implemented in four (4) community mental health centers (CMHC): *Insert Name(s)*.

The Contractor will engage in a collaborative strategic planning process with all relevant partner organizations and collaborate with Project Subcontractors *Insert Names*, in developing a comprehensive program to help support youth as they enter the period of emerging adulthood. The Contractor will facilitate a local advisory council to coordinate with key partner agencies, DHS/DSAMH, and Project RECONNECT Steering Committee to develop a local strategic plan within the guidelines of the project strategic plan for transitional youth

The Contractor will collaborate with Project Subcontractors *Insert Names* in developing a local Youth Action Council and Family Council.

The Contractor will participate with the Partnerships for Youth in Transition information management system so it produces meaningful data relevant to transitional youth.

The Contractor and the local advisory committee will identity the infrastructure barriers and advise on possible solutions. The Contractor and representatives from DHS/DSAMH will collaborate with key stakeholders to design an integrated transitional service system. The Contractor will contact community child-serving agencies to inform them of Project RECONNECT and enlist their support.

The Contractor will commit to sustainability of the project and ensure the continued functioning of the youth transitional services after the end of the federal grant funds.

The Contractor will provide transition facilitation services to a limited group of qualifying youth to test the pilot treatment services.

Pilot Case Management Services

Population Served:
Target population includes both youth who were diagnosed with serious emotional disturbances in childhood and youth with newly emerging mental illness. Only youth between the ages of 14-21 may be admitted to the program, however, once admitted they may continue in the program through age 25.

Treatment (Tx) / Service Requirement:
Services are based on a comprehensive diagnostic evaluation of the medical, psychological, substance abuse, social, behavioral and developmental aspects of the youth and young adult with the expectation that the services offered must be reasonably expected to improve the youth and young adult's transition to successfully transition to adulthood with their full potential.

The Contractor ensures that mental health services provided are flexible to allow youth moving through developmental stages and gaining independence. Interventions are guided by evidence-based practices e.g. solution-focused and skills development interventions. The Contractor and the local advisory committee need to provide services in full-inclusion environments that allow young people to function alongside individuals without disabilities.

Assurance of Cultural Competency:
The Contractor and representatives from DHS/DSAMH will ensure the strategic plan addresses a comprehensive youth and young adult service model that is strength-based, youth centered, family engaged, culturally competent, outcome driven, and community-based.

Contractor's Qualifications:
The Contractor is a licensed Community Mental Health Center by DHS/DSAMH to provide a continuum of mental health services to children, youth and adults.

Transitional Facilitator Staff Requirements:
State of Utah licensed Social Service Worker (SSW). A bachelor's degree in the social sciences, and/or education fields and at least two (2) years of experience working in mental health, social service, juvenile justice, educational and/or settings in which the person provided counseling, training, therapy and/or guidance to children, adolescents, and/or young adults and their families.

Transitional Facilitator Staff to Client Ratios:
At a minimum, the Contractor must maintain a ratio of one (1) FTE Transitional Facilitator staff to 15 clients enrolled in the program at all times.

Staff Training:
General case management or care coordination in areas referred to in staff requirements.

Client Assessment/TX Plan:
Assessment: Within two (2) weeks of program admission, each client must have a current

comprehensive mental health assessment of file. The assessment must contain the following:

1. Must be developed and signed by a licensed mental health therapist in consultation with the client and other individuals who have knowledge of the client.
2. Must contain a history and evaluation of the client's emotional and mental adjustment; social function (including social and interpersonal skills); basic living skills, academic, educational/vocational status; mental and physical health status; living situation and community life functioning.
3. Must include a summary, diagnostic results, if applicable and recommendations for treatment.

Treatment/Service Plan

1. Based on the assessment, an individualized written treatment plan must be developed by a licensed mental health professional.
2. The plan must be developed within one (1) month of the client's admission into the program and include consultation with the client, and when applicable parents/legal guardians.
3. At a minimum, the plan must address the client's strengths and needs in the following areas: emotional and mental adjustment, social function (including social and interpersonal skills); basic living skills, academic, educational/vocational status; mental and physical health status.

4. The plan must include:
    a. Individualized treatment objectives to address the client's needs and prescribe an integrated program of therapies, activities, and experiences to meeting the objectives. Therapies, activities and experiences may include individual therapy; group therapy; medication management, additional or on going diagnostic services and/or skills development, recreational, occupational or other rehabilitative services designed to improve the client's functioning;
    b. A projected schedule of delivery of services including the expected frequency and duration of each type of planned therapeutic session or encounter;
    c. The credentials of the individuals who will deliver the services;
    d. Reasonable measures to evaluate whether the objective are met;
    e. Discharge criteria and at the appropriate time, post discharge plan and coordination with related community services to ensure continuity of care with the client, client's family, school and community;

Review of Treatment Plan

1. The plan must be reviewed and updated at least quarterly or more often as needed if there is a change in the client's condition or status or as determined by the licensed mental health professional responsible for overseeing the treatment program.
2. The review shall include an update of progress toward established treatment and services goals, the appropriateness of the services being furnished and the need for the client's continued participation in the program.

Record Keeping:

Standard DHS/DSAMH and CMHC client treatment file requirements.

Submit all training outlines, agendas, minutes, attendance sheets, and progress reports to DHS/DSAMH every three (3) months starting July 2003. Provide an End of Year Summary by September 30, 2003. The Contractor will provide financial reports monthly to DHS/DSAMH.

Provide a year-end report to DHS/DSAMH, which includes the collection of data for outcome measures and suggestions in determining the barriers for sustainability and solutions to those barriers. At the end of the strategic planning make final recommendations to DHS/DSAMH on policy and procedures, service design, implementation and evaluation.

The Contractor will participate with the Partnerships for Youth in Transition information management system so it produces meaningful data relevant to transitional youth.

Rate:

Cost reimbursement.

Time Line Requirements:

March 1, 2003: Attend the monthly Project RECONNECT Steering Committee and the CMHC's Children and Youth Directors monthly meeting at the State Hospital.

June 1, 2003: Begin the process of utilizing a combination of community partner agencies and Project Subcontractors to outreach to family members by contacting youth agencies with transition age youth and young adults.

June 15, 2003: Begin the facilitation of monthly local advisory meetings and the development of a local strategic plan for an integrated community-based transitional service system.

July 2003, and each subsequent three (3) months: Evidence of program activity will be provided to DHS/DSAMH through training outlines, agendas, minutes, attendance sheets, and program progress reports.

August 1, 2003: Contractor will have hired part-time facilitators/care coordinators to participate with program training. These will be new positions.

September 30, 2003: Promotion of awareness on issues related to transitional youth to community service providers and the general public is in progress.

PART III: PERFORMANCE MEASURES AND CLIENT OUTCOMES

The Contractor shall comply with the following objective based performance requirements:

Outcome 1: By September 30, 2003, the Contractor, in collaboration with Project Subcontractors *Insert Names*, key partner agencies, DHS/DSAMH, and Project RECONNECT Steering Committee, will yield a written Action Plan that describes:

a) Which interventions will be included,
b) How services will be coordinated,
c) The role each partner will play in the implementation of the local program,
d) The steps that will be taken to implement the program,
e) How cultural competency of the program as implemented will be assured,
f) Assist the evaluator in interpreting evaluation results and makes final recommendations to DHS/DSAMH on policy and procedures, service design, and implementation,
g) Funding, and policy barriers that must be overcome in order to sustain the steps that will be taken to overcome policy barriers to long-term sustainability of the program over the long-term.

Outcome 2: By September 30, 2003, the Contractor, in collaboration with Project Subcontractors *Insert Names*, key partner agencies, DHS/DSAMH, and Project RECONNECT Steering Committee, will yield a written Service Scope of Work that includes:

a) General description of service or support
b) Detailed treatment / service requirements
c) Description of the population to be served
d) Contractor's qualifications
e) Assessment requirements for treatment plans
f) Staffing requirements
g) Required staff-to-client ratios
h) Staff training requirements
i) Record keeping requirements

2. **Client Outcomes.** A treatment plan is required for all clients and must include individualized treatment objectives that address the assessed needs of the client. The treatment plan must prescribe an integrated program of therapies, activities, and experiences to meet the client's treatment objectives. The plan must also include reasonable measures to evaluate whether the client's individualized treatment objectives are met.

3. **Customer or Client Satisfaction Surveys:** The Contractor understands that DHS is committed to providing client-oriented services, and that DHS and DHS/DSAMH often conduct client-satisfaction surveys to ensure that services are appropriate for the clients served. Contractor therefore agrees to cooperate with all DHS and DHS/DSAMH initiated client or customer feedback activities.

Appendix 4

Job Descriptions and Staff Qualifications

State Program Coordinator

Job Description

1. Assist Program Director to coordinate a program transitioning youth with mental health difficulties from children's to adult services,
2. Conduct strategic planning,
3. Coordinate and monitor service implementation by community mental health centers to ensure implementation with fidelity,
4. Prepare and present reports,
5. Develop community partnerships,
6. Provide technical assistance to mental health centers on program issues,
7. Organize training events and project related meetings,
8. Facilitate consensus building in meetings,
9. Assist the evaluator to collect and analyze data,
10. Interpret and convey policy and procedures

Qualification:

1. Bachelor's degree in social science, behavioral science, or related fields,
2. Minimum of two years work experience with adolescents and young adults, from diverse cultural backgrounds, with emotional and/or behavioral difficulties,
3. Experience with agencies and organizations that provide services in mental health, substance abuse, education, health, child welfare, juvenile justice, employment, medical, employment and housing,
4. Knowledge and experience in cultural competency,
5. Knowledge of Utah's service system for children, including mental health, substance abuse, education, health, child welfare, juvenile justice, employment, medical, employment and housing,
6. Knowledge in consensus building process,
7. Ability to synthesize and analyze information,
8. Excellent oral and written communication skills, public relations skills, interpersonal skills and facilitation skills,
9. Skills in Microsoft Word.

Supervised by Program Director

Supervisor

Job Description

1. Monitor the implementation of transitional services,
2. Represent the mental health center in the Steering Committee and other community meetings,
3. Develop and maintain inter and intra-agency coordination,
4. Provide clinical supervision to the Transitional Facilitators,
5. Identify areas for quality improvement,
6. Broker and provide technical assistance,
7. Act as liaison between the Transitional Facilitators and the administration,
8. Monitor Facilitators' performances and caseloads,
9. Provide Transitional Facilitators with the necessary resources and support to provide quality services,
10. Develop community partnerships,
11. Assist the evaluator to collect and analyze data,
12. Interpret and convey policy and procedures

Qualification:

1. Bachelor's degree in social science, behavioral science, or related fields,
2. Minimum of two years supervisory experience,
3. Minimum of two years work experience with adolescents and young adults, from diverse cultural backgrounds, with emotional and/or behavioral difficulties,
4. Experience with agencies and organizations that provide services in mental health, substance abuse, education, health, child welfare, juvenile justice, employment, medical, employment and housing,
5. Knowledge and experience in cultural competency,
6. Knowledge of Utah's service system for children, including mental health, substance abuse, education, health, child welfare, juvenile justice, employment, medical, employment and housing,
7. Ability to synthesize and analyze information,
8. Excellent oral and written communication skills, public relations skills; interpersonal skills and facilitation skills,
9. Skills in Microsoft Word.

Supervised by Program Administrator

Transitional Facilitator

Job Description

1. Conduct transitional assessment,
2. Organize and conduct the transitional planning meeting,
2. Provide, arrange, or broker transitional services,
3. Assist young people to achieve competency across transitional domains,
4. Collaborate with key stakeholders, including young people and their families,
5. Promote youth and family involvement in transitional services,
6. Develop crisis/safety plan when appropriate,
7. Monitor young people's treatment progress,
8. Document services planning and provision,
9. Assist the evaluator to collect data.

Qualification:

1. Bachelor's degree in social science, behavioral science, or related fields,
2. Minimum of one year work experience with adolescents and young adults, from diverse cultural backgrounds, with emotional and/or behavioral difficulties,
3. Certificate in case management,
4. Experience with agencies and organizations that provide services in mental health, substance abuse, education, health, child welfare, juvenile justice, employment, medical, employment and housing,
5. Knowledge and experience in cultural competency,
6. Knowledge of Utah's service system for children, including mental health, substance abuse, education, health, child welfare, juvenile justice, employment, medical, employment and housing,
7. Knowledge in conflict management,
8. Excellent oral communication skills, public relations skills; interpersonal skills and facilitation skills,
9. Skills in Microsoft Word.

Supervised by Program Supervisor

Appendix 5

Flexible Funds Request Protocol

Flexible Fund Request Protocol
Project RECONNECT

Overview -

Flexible funds may be requested for youth participating in Project RECONNECT in an effort to assist them in obtaining necessary services or resources to facilitate a successful transition. Examples of acceptable funding usage include one time deposit and/or first month rent, utilities, job-related tools or uniforms, furniture or personal items, and transportation (bus passes, vehicle repair, etc.), Unacceptable funding usage include, movies and entertainment, extracurricular registration fees, court fines, etc.

Guidelines -

1. Funds up to $400.00 may be approved by the Project Coordinator and project staff.
2. Any amount over $400.00 must gain approve through the Partner's for Youth Transition (PYT) Committee.
3. All requests need to include the youth's name and purposes of the money.
4. Request forms must be completed fully or will be returned to the worker.
5. Project Coordinator will provide a spending report to the PYT Committee at their monthly meeting.

Process -

Once the funding request has been submitted and approved by the Project Coordinator. The coordinator will request a check disbursement through the purchasing office at Valley Mental Health. The check will be written to the vendor/provider of those services. A receipt or proof of payment will need to be submitted back to purchasing at the end of the transaction. Lezli Burt, Office Manager for CARU will be the contact person for this process.

Flexible Fund Request Form
Project RECONNECT

Date Requested:_____

Youth:_____ Facilitator:_____

Purpose of funding: _____

_____

_____

_____

Amount requested: (if over $400.00, PYT approval is required) _____

Other funding options explored: _____

_____

_____

Whom check should be written: _____

Youth Signature: _____

Facilitator Signature: _____

Date Reviewed: _____

☐ Approved (Amount, if different from request amount) _____

☐ Denied Reason for denial _____

_____

For amounts over $400.00,

PYT Chair Signature_____ Date: _____

Appendix 6

Family Curriculum

GROWING UP WITHOUT GROWING APART

Finding your way
to your Child's Adulthood

A curriculum designed by parents for parents who have a youth/young adult
transitioning into adulthood.

A Project produced by the Family Advisory Council of
Allies with Families
Utah Chapter of the Federation of Families for Children's Mental Health
and
Project RECONNECT

This curriculum was generously funded by
a grant to the State of Utah
Division of Substance Abuse and
Mental Health

By

The Center for Mental Health Services
Substance Abuse and Mental Health Services Agency
of the Federal Government

The Utah Chapter of the
Federation of Families for Children's Mental Health
450 E. 1000 No. #311
North Salt Lake, Utah 84054
(801) 292-2515
(801) 292-2680 FAX
awfamilies@msn.com

Forward

One of our goals as we developed this course, was to help parents have some of the tools we wished we had as we started down the road of raising a child with a serious emotional disturbance. We have experienced some things that we did not want other parents to have to go through.

Keep in mind, that this is a work in progress. This is a beginning and we will be revising and learning as we teach from and use this text. Most of the information contained within is basic, and yet when we first started, we were so overwhelmed that we needed reminders about the basics.

Hopefully, you, as parents and caregivers, can use some of the information presented and one day be in a position to "give back" some of the insights, gifts, and talents, you have gained as a result of working with some very special and very challenging youth.

A very special thanks to....

...the members of the Allies with Families' Family Advisory Council for Project RECONNECT, Utah's Partnership for Youth in Transition Federal Grant:

Walter and Donna Brodis
Nancy Dollmeyer
Craig and Tena Beckstrom
Colt and Dawna Holt
Rolf and Pamela Sorensen
Barbara Zabriskie
Eraine Albretsen
Linda Melton
Patricia Baker, Staff of Allies with Families
Lori Cerar, Staff of Allies with Families
Jane Lewis, Project Coordinator, Project RECONNECT

GROWING UP WITHOUT GROWING APART: Finding Your Way to Your Child's Adulthood

INTRODUCTION

Hannah's Story

My name is Leah*. At 2 years of age, my daughter, Hannah, was diagnosed with intractable Grand Mal seizures. In the many attempts to control her seizures, she has had numerous medications prescribed with limited to moderate success. As a result of the many medications, usually prescribed at higher doses, as well as the continuing high seizure activity, Hannah now suffers with limited cognitive and reasoning abilities and has an IQ of 75.

Beginning in the spring of 2001, Hannah, then age 15, began exhibiting severe symptoms of an emotional disorder. She was having problems at school and being sent home frequently. She was becoming physical and verbally violent at home and at school. She was stealing and lying. She was hearing voices. The police had to be called many times resulting in involuntary transport to a psychiatric hospital. Over the next three months, she was admitted six times to a psychiatric facility for Severe Emotional Disturbances. This totaled 52 days of intensive inpatient treatment, sometimes including seclusion and restraints. She received outpatient therapy and medications when she was not inpatient.

During these admissions, she was diagnosed with Bi-polar Disorder and Intermittent Explosive Disorder. At that time, I was a single mother struggling to find any assistance for my daughter as well as provide a living for both of us. I had nearly exhausted all of her private insurance benefits and was denied any Federal or State assistance because my income was too high.

After moving to a different state with my new husband, we struggled desperately to find any day program, therapy sessions, or a mental health program to assist Hannah. I spent many days on the phone calling EVERYWHERE searching for help, often times ending up at the first number that I had called.

Hannah was eventually admitted to a day program after I got an extension in her psychiatric benefits. But in two weeks, it was determined that she was in need of more help than they could provide. We were told she needed residential/long term care, which we had been told before. She had two more inpatient admissions during that two-week time period as well, bringing the total to eight acute admissions in 5 months.

Hannah was clearly a threat to herself and others. We desperately continued our quest to find appropriate treatment for our daughter. On her last psychiatric admission when she was being prepared for discharge, we refused to pick her up because she was in such dire need of help and we couldn't provide it or find it anywhere. The hospital seemed unwilling or unable to assist in finding care for her outside of their facility. We were threatened with child abandonment charges but we felt strongly that we had no other options. Hannah needed care—and now, not later.

Finally, with the assistance of a local law center, we were able to convince the Department of Services with Disabilities to convene an emergency session in Hannah's behalf. They agreed to admit Hannah to the state's Developmental Center for observation and medication review.

After a nine month review and stabilization period, Hannah was relocated to a group home where she still resides and is making good progress. She still takes several medications, both for seizures and behaviors. She is now almost 19 years old. She has successfully completed high school and has received her certification of completion. She is attending a post secondary school for people with disabilities and trying to learn how to function in society to the best of her abilities.

Hannah will always have problems. We will always have set backs with her and we will always have triumphant victories to celebrate. We know this, we have learned this. But we will continue to support Hannah in any way possible. We will continue to learn as much as we can to help her and others like Hannah, and other parents like us.

*Names changed to protect the privacy of those in the story.

Facts on Transitional Services for Youth with Mental Illnesses

Providing comprehensive support services to youth with mental illnesses transitioning into adulthood is critical to their success. Many youth age out of children's services without any transitional planning and lack skills necessary to manage their illnesses and accomplish their goals. These youth face the challenge of entering adulthood without proper services and support.

Prevalence

- More than 3 million transition age youth have been diagnosed with a Serious Mental Illness.

- Adolescents transitioning to adulthood with a Serious Mental Illness are three times more likely to be involved in criminal activity than adolescents without an illness.

- Incarcerated youth age 18-22 are more likely to have a mental illness than younger adolescents in the juvenile justice system.

- Transitional age youth with a Serious Mental Illness have higher rates of substance abuse than any other age groups with mental illness.

- Rates of Serious Mental Illness are highest among young adults age 18, and rates decrease for each year thereafter.

Unmet Needs and Consequences

- **Education and Employment.** Young adults with a Serious Mental Illness face many challenges when transitioning from school to adulthood. Over 60 percent of young adults with a Serious Mental Illness are unable to complete high school.

- These young adults are often unemployed, unable to participate in continuing education, and lack successful skills necessary for independent living.

- **Increased Risk of Suicide.** An estimated 20 percent of youth receiving treatment for emotional or behavioral problems have either contemplated suicide or attempted suicide. Less than 40 percent of youth at risk of suicide receive treatment. Suicide is the third leading cause of death among young adults age 15 to 24.

Effective Services

- **Individualized Services.** Youth in transition need services that assist them in employment, housing, and education. Research shows that these services are most effective when they are tailored to meet the goals of each young person. Services and supports also need to be developmentally appropriate in order to build on the strengths of youth in transition.

- **Personal Responsibility and Parental Support.** Services are most effective when youth are able to develop problem-solving skills and learn to experience consequences through their decisions. ***Parental involvement is key in guaranteeing that youth have a safety net of support.***

Barriers to Meeting Needs

- **Gaps in Services.** No system or agency is responsible for youth with mental illness transitioning into adulthood. Youth with mental illness may be involved with service systems such as special education, child welfare, and juvenile justice. When these youth age out of their respective youth system they are often ignored or neglected in the transition period to adulthood.

- **Under Utilization of Services**. Many adolescents and youth in transition do not receive specialty services despite the availability of services. This is often due to the stigma associated with mental illness and mental health services. Furthermore, cost of services and dissatisfaction with services prevent youth from receiving treatment.

- **Lack of Support**. Many transitional youth lack the personal connections and friendships necessary for successfully managing their illness. Transitional youth are often separated from their families and do not receive adequate support.

Recommendations

Policymakers can promote improved treatment by:

- Creating a comprehensive service system for youth in transition that extends services between adolescence and adulthood.

- Encouraging the adult mental health system to develop programs and services for young adults age 19-25.

- Ensure continued Medicaid eligibility through age 24 for youth on SSI at age 18.

- Providing funding to SAMHSA in order to increase technical assistance, research, and demonstration projects to develop proven services specifically designed for transitional youth.

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Bibliography to Introduction

Facts on Transitional Services for Youth with Mental Illness, Judge David L. Bazelon Center for Mental Health Law

SECTION 1: INDEPENDENCE VS. INTERDEPENDENCE

Jane's story…

Jane and Sarah are sisters who are two years apart in age. Jane is currently 30 years ole, married and raising Sarah's two daughters, ages 11 and 6. Sarah is currently living in another state because of outstanding warrants for her arrest. Sarah has never been married, never finished high school, has been in and out of jail, and each of her two daughters have different fathers.

Jane's story of mental illness began more than twenty five years ago but it is not a story of her own mental illness but a story about the effects of Sarah's mental illness. At that time, Jane didn't know anything about mental illness; she just knew that her sister was always getting into trouble. In fact, at that time, Jane didn't know that eventually she was going to raise Sarah's daughters as her own and have a story to tell about the experience.

Jane was always feeling the effects of Sarah's behavior. She was always finding her missing things in Sarah's drawer, always having to hear her parents struggling to deal with Sarah's bad grades and disruptive behavior, always wondering if she was going to have the same problems and promising herself that she never would.

All through school, Jane never felt comfortable having her school friends come to her home to play. When she started high school, she always had the feeling she was being looked at differently. When she realized that others at school knew she was Sarah's sister, she did her best to be completely different than Sarah, but only those few who really got to know Jane, really found out who she was.

Eventually Jane's father left home and so did Sarah. Jane's father left because he couldn't deal with Sarah's ongoing behaviors and the doctors who could never decide what was wrong with Sarah or offer her any help. Sarah left because she couldn't deal with all the rules.

Finally Jane began to blossom. Jane found out who she was and she was able, at last to have a life without the constant pain of Sarah's behavior.

Then Sarah became pregnant with her first daughter, Ashley. If Sarah wasn't drinking, smoking or having "scored" with some kind of drug, she was suffering through horrible depression. Ashley's birth was uneventful and Sarah finally seemed to have a normal start to a new life as a mother but this didn't last for long. Ashley was being cared for more and more by Grandma and Aunt Jane than she was by her mother. Five years later, Brianna was born. During one of Sarah's periods of incarceration, Sarah was diagnosed with Acute Personality Disorder.

Jane and her husband Robert were married 8 years ago. When Brianna was 3, she began to live permanently with Aunt Jane and Uncle Robert. Six months later, Ashley began to live with Aunt Jane and Uncle Robert as well.

After several years of frustrating negotiation, prayers and legal expenses, Jane and Robert adopted Brianna and have permanent legal custody of Ashley. The "girls" seldom see their mother and almost never see their fathers, respectively.

Brianna has always been a normal child but Ashley has always been a bit over the edge. Jane has worked to correct Ashley's learned behaviors from her mother. But Jane is now seeing the troubling images of Sarah's physical behaviors from her past, which are now being manifested in Ashley.

Jane and Robert are working as a team to deal with Ashley's behaviors and struggling to find a child psychiatrist or therapist to work with Ashley. The biggest challenge is finding the correct diagnosis and a method to help Ashley without the heavy drugs usually prescribed for this mental illness. As Ashley's psychiatrist has said, there are not a lot of established criteria to diagnose a child of 11 with Acute Personality Disorder, but from Jane's past experience, she is pretty sure that this is what Ashley suffers from.

The final chapters of Jane's story of mental illness will not be written for many years yet, but Brianna's story of mental illness is just beginning. Brianna will have much more help in writing her story, because Jane knows a great deal about what Brianna's story will be like.

Types of Relationships

- Independent – prefers a very loosely constructed connection. He or she does not want to feel either dependent on or depended on by the other partner.

  - If you give a lot to this type of person, don't expect to get a lot in return..

- Dependent – the opposite of independent, this person wants very close connections. He or she lacks the ability to make decisions or function apart from their partner and may be described as clingy.

  - This person draws feelings of confidence or self-worth from another.

- Codependent – an extreme caregiver. This person gives more than is healthy for a relationship. They want to make everything okay for everyone.

    - They put significant time and effort into helping others achieve their goals while feeling guilty about taking even a little for themselves.

- Interdependent – strikes a healthy balance between giving and taking. Their sense of self-worth is not linked to others.

    - They can give without hurting themselves and take without feeling guilty.

Healthy Relationships

The best personal relationships are built on:

- Mutual trust
- Mutual respect
- Effective communication
- Kindness
- Patience
- Forgiveness
- Mutual support
- Shared interests
- Similar values

ACTIVITY:
Defining Relationships

- Draw a circle with 5 layers
- Put your name in the middle
- Put the names of people most important to you in the rings closest to your name.

- List less important people in the outside rings
- Highlight the relationships that contribute most positively to your success in one color and the negative ones in another color.

Conflict in Relationships

- Conflict is a product of our being different from each other and not always seeing the world in the same way.
- The goal is not to avoid conflict but to maintain a healthy relationship even in the midst of conflict.

Road to Interdependence

"In a new way all people are caught in an inescapable network, tied to a single garment of destiny. Whatever affects one affects all directly. I can be what I ought to be until I am who I ought to be. This is the undisputed structure of reality."

Martin Luther King, Jr.
"Notes from a Birmingham Jail"

TAKING CARE OF YOURSELF

Pamela's story..

"By no means is this in any way over, for things to change……Do we have options?" (Is this the title of the story?)

Since we became aware of NAMI six years ago, my husband and I have discovered that NAMI has been the help we needed to survive the journey of mental illness. The trials do not end and the pain can return. **The unknown will always exist.** At least we know we are not alone. This gives us strength to press forward, and more importantly, we have learned to share that hope to encourage others.

We wish we had known about Allies with Families when our children were younger. Don't we all wish we could pick our own battles and time frames! Allies with Families focuses on that period of transition from youth to adulthood. My husband and I are involved with Allies with Families on a research and development program (a model curriculum for the state) with several other parents/caregivers in the hopes of helping families transition their youth through these nightmarish experiences.

I am a family member, an Allies with Families researcher, a certified BRIDGES and Provider Training Instructor for NAMI, and now an Affiliate of Development of NAMI Utah. But the two most important titles I have are that of *a devoted wife* and *the mother of 3 adult children who suffer from serious mental illness*.

In 1995, our son, now 29 years old, was unexpectedly sent home from his church mission which was in Nebraska. He became very, very mentally sick there. When he got off the airplane, he looked like an Auschwitz survivor from the Nazi torture camps. Our lives literally changed. We were thrown into a completely different world, a place where we had to learn what denial was and what mental illness was. It was a terrifying, unforgettable adjustment for our entire family. We are still adjusting. He was/is suffering from an illness not visible on the outside. His behaviors painfully surfaced to Schizo-Affective Disorder. *"More mental hospital beds are occupied by people with Schizo-Affective Disorder, which is relatively newer than any other major mental illness."*

We later learned our oldest daughter, who was a runaway, married a man who has Bipolar Disorder. The have 4 children between them but, because of their mental illnesses, they have completely disowned all family members on both sides. They are seriously paranoid about their whereabouts. We do know we have grandchildren, 3 girls and 1 boy, which we have never seen. As of this writing, today is our oldest daughter's 30th birthday.

Our youngest daughter, now 23 years old, suffers from Bipolar Disorder, ADHD and Borderline Personality Disorder with regular panic attacks associated with anxiety. Now we reflect back, realizing her illness began at age 13. Recently, she has become tied up with the legal system again. She has self mutilated because of the pain she cannot bear. One would hope and think the legal system would adjust to these severe mental disorders. This is not so. Besides being a slap in the face, it becomes humiliating, costly, and one gets discouraged once in the legal system.
The legal system finally is slowly making changes such as mental health courts. In the meantime, however, incarceration is good for the legal system. We build more prisons and jails, purchase assets, and create jobs based on mental illness. We destroy individuals and families and pass the costs on to America. It is a self perpetuating cycle. Up front, the health care system temporarily saves money. Rather than treat those with mental illness with the proper medication and/or treatment, they are sent to jail because of their actions. It really boggles the mind to think this is happening. As a member of society you may ask the question, **"What are the real costs of mental illness?"**

All three of our children have challenges with substance abuse as well which creates a dual diagnosis, the most challenging and complex. Because of these findings, my husband and I have accepted a new quest in life, one that motivates us to rise above the stigma that intensifies mental illness ….. pain that doesn't go away. Names and labels aren't as important as it is to listen to the voice of mental illness, and to learn and understand that new language.

"We would like to be known by the company that we keep." That company is our family. We are their company, hopefully forever. We both are willing to accept the mental illness challenge. You do have a choice. You can either run or fight. When it comes to mental illness, my husband and I deal with the same things many others do. Many others deal with the same things we do. We will all choose how we deal with our "company". **No one is exempt ~ it can happen to anybody.**

My husband and I have faithfully taught for the past five years a 10-week BRIDGES course (an education and support program for consumers of mental health sponsored by NAMI). Just recently a question was asked by one of our consumers in the class. He raised his hand, looked at me and asked, **"Tell me, HOW DO YOU DO IT? When your daughter, who you obviously love and care for, has an episode and becomes controlled by her illness, when she screams vulgarities, threats, and obscenities at you, how do you control yourself and take it without falling apart or losing control of yourself? That has got to be painful!"**

I took a deep breath and smiled as I looked down. I firmly patted the BRIDGES manual that was lying in front of me, looked up, and replied to him, "Yes, it is more painful than I can describe **It is the education and support I have been learning and teaching through NAMI that has been, and will forever be, my own personal strength.** That is what has helped me withstand the frightening things that take place with mental illness. Without constant learning by studying these illnesses, I KNOW I COULD NOT DO IT ALONE. No one can do it alone … NO ONE. I have learned to mentally, physically, and spiritually remind myself to "separate the person from the problem". Those words have become a lifesaver for me. I learned them from attending my first NAMI "Family-to-Family" course.

That was the beginning for my husband and me, who did not attend willingly at first. This is when we realized how vital it is to educate and take care of ourselves before we even attempt to help our children, something we both unknowingly thought we could do on our own. At that time, we did not know our other two children were also suffering from mental disorders. The delay in our learning only compounded the horrible experiences we were going through. Things had been going on inside of them we knew nothing about. All three of them grew up in the scary world of mental illness. This was not of their choosing, or of ours, but it has miraculously led us to where we are now. We are strong advocates for "Utah's Voice on Mental Illness".

For families living with people with disabilities, the problems that arise in getting through one day can be overwhelming. Families who have a person with a disability have all the same problems and obligations of ordinary families. They also have the added burden of the extra needs of that person. These families' lives are different than the lives of most families. Talking to people who have had to get through days much like their own provides an outlet that can't be found anywhere else.

Parents of young adults with disabilities feel there are a lot of things they "should" be doing. There are also a lot of things they think others, including teachers, doctors, relatives, counselors, expect of them.

What Is Taking Care Of Your Self?

Working with people can be stressful. Working with persons who are poor and who suffer from mental illness can be even more stressful. It is important to take care of

yourself – physically, emotionally, and socially. You may have opportunities to attend time management and stress management workshops. At workshops, they will go into more detail about coping with the challenges of your job and your life.

How To Take Care Of Your Self

Time Management

- ✓ Make a daily plan of tasks.
- ✓ Prioritize the list. Identify those tasks that have to be done today (A's) from those which should be done, but could be done tomorrow (B's), and those which are not that important (C's).
- ✓ Be sure to do your "A" tasks first.
- ✓ Keep lists simple and realistic.
- ✓ Carry your list with you – consult with it often.
- ✓ Let your list be your guide, not a ball and chain. You will find that you often have to adapt and revise.
- ✓ Be on time. Treat co-workers and family members the way you want to be treated.
- ✓ Make a "grass-catcher" list. This is an ongoing list of things to be done, without a specific deadline. When you are making your daily "to do" list, consult this "grass-catcher" list.
- ✓ Always ask 'what is the best use of my time right now?'
- ✓ Don't do other people's "A" tasks at your expense.

MANAGING STRESS

What Is The Real Reason We Feel "Stressed"?

People say one of the main reasons they feel stressed is that they don't have time to think anymore. E-mail, voice mail, cell phones, pagers, faxes, and overnight mail all create a sense of urgency.

In the "good old days," we had longer work weeks (42 hours in 1952 vs. 40 today). There was downtime between tasks – to lick a stamp, walk to the mailbox, change a typewriter ribbon, flip through a dictionary, or dial a phone number.

What you can do?

TAKING CHARGE OF YOUR EMOTIONS

"You have the capacity to choose what you think about.

"If you chose to think about past hurts, you will continue to feel bad.

While it's true you can't change the effect past influences had on you once, you can change the effect they have on you now."

Gary McKay, Ph.D.,
Author of How You Feel is Up to You:
The Power of Emotional Choice

Make a concerted effort to be the master of technology in your life.

1. Limit your use of gadgets. (An amazing number of people are getting rid of their car phones. They want to reclaim the private time between home and work.)
2. Limit the number of people who have access to you through technology (i.e., don't give out your access numbers to everyone).
3. Limit the amount of "information" that comes into your life (it makes no sense to listen to radio and TV news reports).
4. Unplug technology regularly. The world doesn't need you to be on call 24 hours a day.
5. Make a special effort to connect with real things – people, animals, nature, music, art, play, laughter, and exercise.

Recognize the stages of burnout:			
Stage I – Early Warning Signs	Stage II – Initial Burnout	Stage III – Burnout	Stage IV – Burnout
Vague anxiety Constant fatigue Feelings of depression Boredom with one's job Apathy	Lowered emotional control Increasing anxiety Sleep disturbances Headaches Diffuse back and muscle aches Loss of energy Hyperactivity Excessive fatigue Moderate withdrawal from social contact	Skin rashes Generalized physical weakness Strong feelings of depression Increased alcohol intake Increased smoking High blood pressure Ulcers Migraines Severe withdrawal Loss of appetite for food Loss of sexual appetite Excessive irritability Emotional outbursts Irrational fears (phobias) Rigid thinking	Asthma Coronary artery disease Diabetes Cancer Heart attacks Severe depression Lowered self-esteem Inability to function on job and personally Severe withdrawal Uncontrolled crying spells Suicidal thoughts Muscle tremors Severe fatigue Over-reaction to emotional stimuli Agitation Constant tension Accident proneness and carelessness Feelings of hostility

- Take action to deal with your burnout if your recognize it.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.
- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them

- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits for yourself and others. Know your own boundaries.
- Exercise regularly.

"*Often the person who identifies himself as the curer or fixer-type healer is vulnerable to burnout."* (Rachel Naomi Remen, MD)

"Perhaps the most important thing I have learned from my work is that I can be a friend and supporter of healing; I can be a guide to people; but it is not I who does the healing. I try to heal by creating situations that seem to allow or foster healing – calmness, faith, hope, enthusiasm – and sometimes just the idea that healing is a possibility." (Martin Rossman, MD)

ACTIVITY:

1. WRITE DOWN ALL THE PEOPLE YOU ARE. (Possible answers: mother, father, sister, brother, aunt, uncle, teacher, coach, etc.)

2. **WRITE DOWN ALL THE PEOPLE THAT EXPECT SOMETHING FROM YOU. (**Possible answers: children, clergy, husband, wife, mother, father, etc.)

3. **WRITE DOWN YOUR EXPECTATIONS OF YOUR CHILD.** (Possible answers: have friends, finish school, go to college, etc.)

The list can get so overwhelming that finding time to attend a parent support group itself seems impossible. If parents look at their list of things to do they may notice that some of the things listed could be done more easily (or might have

already been done) by a group of parents who share some of the same experiences

GRIEF

What Is Grief?

Grief is a natural and normal reaction to loss. **You need to go through grief to heal** – and ultimately experience emotional growth.

Grief can bring a wide range of emotions. These can range from deep sadness to anger. Some of these feelings may be new or frightening to you. Accepting that these are normal reactions is the first step on your road to healing.

You can find ways to deal with your pain. There are many healthy ways to cope with grief. You can find ways that work for you (i.e. parent support groups, education classes, grief counselors, family therapy, individual therapy, etc.). And there's plenty of help whenever you need it.

Grief can follow many kinds of losses. The death of a loved one may cause the most intense grief. But grief can also follow other losses, such as:

- ☐ A miscarriage
- ☐ A divorce or separation
- ☐ Learning you have a disability or serious illness
- ☐ The death of a pet.

These losses can bring reactions much like those that follow the death of a loved one.

Why Is It Important To Grieve?

Welcome to Holland – by Emily Perl Kingsley

I am often asked to describe the experience of raising a child with a disability – to try to help people who have not shared that unique experience to understand it, to imagine how it would feel**. It's like this**…

When you're going to have a baby, it's like planning a fabulous vacation trip – to Italy. You buy a bunch of guide books and make your wonderful plans. The Coliseum. The Michelangelo David. The gondolas in Venice. You may learn some handy phrases in Italian. It's all very exciting!

After months of eager anticipation, the day finally arrives. You pack your bags and off you go. Several hours later, the plane lands. The stewardess comes in and says, "Welcome to Holland."

"Holland?!?" you say. "What do you mean Holland?? I signed up for Italy! I'm supposed to be in Italy. All my life I've dreamed of going to Italy."

But there's been a change in the flight plan. They've landed in Holland and there you must stay.

The important thing is that they haven't taken you to a horrible, disgusting, filthy place, full of pestilence, famine and disease. It's just a different place.

So you must go out and buy new guide books. And you must learn a whole new language. And you will meet a whole new group of people you would never have met.

It's just a different place. It's slower-paced than Italy, less flashy than Italy. But after you've been there for a while and you catch your breath, you look around…. and you begin to notice that Holland has windmills…and Holland has tulips. Holland even has Rembrandts.

But everyone you know is busy coming and going from Italy…and they're all bragging about the wonderful time they had there. And for the rest of your life, you will say" Yes, that's where I was supposed to go. That's what I had planned."

And the pain of that will **never, ever, ever, ever go away**…because the loss of that dream is a **very, very significant loss**.

But…if you spend your life mourning the fact that you didn't get to Italy, you may never be free to enjoy the very special, the very lovely things…about Holland.

When Is It Appropriate To Grieve?

Ask the participants to suggest some feelings they have experienced. Write feelings down on the board/pad as people suggest them. Use the list below for "coaching".

Denial; Fear; Guilt; Sorrow; Grief; Disruption of Family relationships; Exhaustion of spirit and resources; Difficulty accepting the illness; Sleeplessness; Shame; Anger; Rage; Isolation; Confusion; Frustration; Depression; Apprehension about the future; etc.

What separates us from a lot of traditional thinking in the mental health field is this: **We believe these reactions are perfectly normal responses, given the catastrophes we are trying to adjust to**. (Just look at all the traumatic emotions up on the board!) We believe that we have a right to our feelings, and that we need to understand and express them. So let's spend some time learning about the predictable stages of our emotional reactions to mental illness.

Everyone Grieves Differently

How you grieve may depend on many factors. These include:

The circumstances of the loss. **Every loss is hard**. But grief may be especially intense, complex or lengthy if you lost someone very close to you, or if the cause of death is unknown or unusual. For example, grief may be especially hard when the loss is:

- ☐ The death of a child, parent, spouse or life partner
- ☐ A sudden or violent death
- ☐ A death due to suicide.

Things about yourself. Personal factors can also affect your grief. These include your:

- ☐ Gender – In general, males and females have been taught different ways to handle stress and emotions. As a result, they often choose different ways to acknowledge and express their grief.
- ☐ Age and life experiences – These can affect your understanding of death and your sense of self when you experience a loss.
- ☐ Culture and faith – These may influence your beliefs about death and your responses, such as your choice of rituals for honoring someone who has died.
- ☐ Personality – Different personality traits (such as being outgoing, shy, expressive or thoughtful) often lead to different ways of coping with loss.

TRY KEEPING A JOURNAL. This is a safe way to let out your feelings and thoughts. It can also be a way to say goodbye to your loved one. You might feel sad when you write. But you may also gain insight and a sense of relief.

Anyone can keep a journal. You don't need special skills, tools, or lots of time. You don't need to be a writer. Any notebook will do. And you can write for just a few minutes between tasks if you're busy. (You can try tape recording your thoughts and feelings if you'd rather not write.)

Spelling and grammar don't matter. Journal writing doesn't need to be proper or sound nice. The goal is simply to get down on paper whatever is in your heart and on your mind.

Your journal is for you only. Journal writing is a way you can express thoughts that you aren't comfortable saying aloud or that you want to keep private for any reason. You can share your journal with others if you'd like. But you don't have to.

STAGES OF EMOTIONAL RESPONSES
I. Dealing with Catastrophic Events
Feelings: Crisis/Chaos/Shock Denial; "normalizing" Hoping against hope
Needs: Support; Comfort; Empathy for confusion; Help finding resources, Crisis Intervention; Prognosis; Empathy for pain; Allies with Families and/or NAMI
II. Learning to Cope
Feelings: Anger/Guilt/Resentment Recognition Grief
Needs: Vent feelings; Keep hope; Education; Self-care; Networking; Skill training; Letting go; Cooperation from the system; Allies with Families and/or NAMI
III. Moving to Advocacy
Feelings: Understanding Acceptance Advocacy/Action
Needs: Activism; Restoring balance in life; Responsiveness from system; Allies with Families and/or NAMI

You all recognize that mental illness has had an enormous impact on your lives. What you may <u>not</u> know is that you tend to respond to this trauma in characteristic and predictable ways. Many family members and family-member professionals have written about this "emotional response cycle" we all go through. It is such an important aspect of our course that we will go over it now in some detail.

There are some important points to emphasize here:

1. None of these stages are "wrong" or "bad". They are normal reactions everyone experiences when struggling to cope with serious illness and trying to deal with critical disruptions in their lives.
2. This process is ongoing – for most of us it has taken years. The process is also cyclical; we will

start it all over gain every time our relative has a relapse, or suffers a serious setback.

3. Different family members are often at different places in the cycle, which is why we sometimes have difficulty communicating with each other and agreeing on what to do.
4. This developmental account is not about expectations. This is a human process that you do your way. If you know where you are in it you can be gentler with yourself. We think it offers hope to see that we do progress through pain and grief to acceptance.
5. As you get to know each other better in this class, you will begin to recognize these stages and emotional reactions. In this way, "old timers" help "newcomers;" we inform each other, we validate our feelings.

Do these stages look familiar to you?

It is vitally important for family members to learn about these emotional responses because where we are directs us to what we need in any given stage of the cycle. For example, look at what we need when going through the hard times of dealing with a catastrophe.

By stage 2, we are full of emotion and have a different set of needs. We need to "sound off", learn to cope, learn all about the illness.

And by stage 3, we are getting it together. We need to restore the balance in our lives; we find purpose in advocacy and action; we help others.

R E S O U R C E S

Allies with Families
Family to Family Classes for families with children under the age of 18
Call 1-877-477-0764 to find a class in your area

NAMI – Utah
Family to Family Classes
Call 1-877-230-6264 to find a class in your area

Support Groups listed in the back of Dreaming New Dreams/Loosen Up Section

Bibliography for Taking Care of Yourself:

1. *NAMI – Family to Family Education Program*
2. *Allies with Families – Family to Family Education Program for children under the age of 18.*

ARE YOU TAKING CARE OF YOUR SELF?

Take this simple test and see how you score. Often we get so wrapped up in the minutiae of our lives, we forget the bigger picture. If your score is low, make needed changes and see how you score in six months.

	VERY MUCH SO → NOT AT ALL				
	5	4	3	2	1
o **I feel my life matters.**					
o **I am living my dream.**					
o **I feel the energy of optimum health.**					
o **I have "nutritious" people in my life.**					
o **I enjoy being alive.**					
o **I regularly enjoy hearty belly laughs.**					
o **I take time for solitude.**					
o **My recreation re-creates me.**					
o **I take time to nurture my soul.**					
o **My life is balanced**					
o **I have the courage to say "no".**					
Source: The Hope Heart Institute, Seattle, Washington					

Not to Worry

"We are rapidly becoming a nation of nervous wrecks, but the problem is hardly a new one.

It's been observed that 40% of the things we worry about will never happen, 30% happened in the past and can't be changed, 12% reflect needless health concerns, and 10% represent petty, miscellaneous details.

That means only 8% of our worries are legitimate.

So how much better would we all feel if we eliminated 92% of our worries?

Chances are we'd feel more relaxed, become more productive, and sleep better.

We could also spend a lot less money on tranquilizers, antidepressants, and sleeping pills.

As Thomas Jefferson once wrote to a loved one, "How much pain has cost us the evils which have never happened.'

No one would argue with that.

Now, if I could just figure out which 8% of my worries I really do need to worry about, I'd feel so much better."

Mary O'Brien, MD, in American Medical News, Vol. 40, No. 39

Common Reactions to Loss

Here are some common feelings and responses that a loss can bring. Not everyone experiences all of them. Some people have reactions not listed here. And often, reactions that have come and gone return later in the grieving process.

It's important to be aware of your feelings. You may find it helps to check off the reactions you had or are having. You can write down any others in the spaces provided.

Shock and disbelief

This is a typical first reaction after learning of a loss. It's nature's way of protecting you from the impacting of the loss for a while. You may:

- ☐ Have trouble believing your loved one is gone
- ☐ Feel numb or like you're on "automatic pilot"
- ☐ Keep expecting your loved one to show up, even though your rational mind knows he or she won't
- ☐ Have a sense of being in a dream.

Other reactions you had or are having:

Anger or resentment

This is common, even if there is no one to blame for the death. You may:

Feel like a great injustice has been done
Be angry at doctors, relatives and others
Be angry at God
Resent your loved one for dying and leaving you alone.

Other reactions you had or are having:

Guilt

It's normal to regret things you did nor didn't say, do or feel. Some people may regret or feel guilty for:

Not doing something (or not doing more) to prevent the death
Not being there to say goodbye
Being relieved that the person died (in case of death after a long illness)
Having arguments with their loved one while he or she was alive.

Other reactions you had or are having:

Fear

A loved one's death can cause you to feel worried, panicky or helpless. You may:

Feel unable to handle new responsibilities
Worry that you're losing your mind
Have fears about your own death
Be afraid to face life without your loved one.

Other reactions you had or are having:

Deep Sadness

Sadness may be a constant presence or hit you all of a sudden. It's common to feel:

Lonely
Like there's a hole in the center of your life.
A deep yearning
Like you're reliving all the other sadnesses you've had in your life.

Other reactions you had or are having:

SECTION 2:
PERSON-CENTERED PLANNING

Jenny's Story –

Jenny received her certificate of completion from high school. Her IEPs had always been written mostly around her academic needs, i.e., counting to 100. They did not address such things as her life dreams or even her daily goals.

Jenny lives in a small group home and has for 3 years. She enrolled in a 4-year post secondary public school in the fall after high school. This school is specifically designed for youth with disabilities of all kinds. The first 3 or 4 meetings Jenny and her parents had with her new teaching staff were devoted to creating a "Person Centered Plan" (Plan) for Jenny. Jenny's program coordinator from her group home attended the meetings also. Most often, Jenny was asked what she liked to do, what she wanted to do for recreation, for a job, and what she felt like she needed help with. The Plan also considered her special needs regarding her disabilities. Her Plan zeroed in on her talents, her strengths, her goals and her dreams instead of trying to get her to do something that she was not capable of, i.e, counting to 100.

Jenny has flourished in the 6 months of functioning under HER Plan. She takes more pride and responsibility for her chores, her volunteer job, and she can even keep her own checkbook organized and pay her own bill on time. She is beginning to feel like a part of adult society, like she is valuable and productive. Her Plan involves her school, her group home, her job and her job coach, and her parents. It has consistent goals and disciplinary actions for her to follow no matter whether she is at home, school, work, or in the community.

Jenny still has a long way to go and will always need some assistance. But with her Plan she will be able to function as an adult to the best of HER abilities, just like the rest of us.

What is Person Centered Planning?

Person Centered Planning provides a process or structure that assists people to plan and implement their plan. It can be the vehicle for helping people to plan for a job or career or a place to live. It can produce results that will further the inclusion of people with disabilities into activities and environments with other people in their communities.

Goals and objectives are made that help the student achieve a life that makes sense for them, whether or not a person is in school.

A commitment is required from the student and all the people who support him/her: parents, siblings, friends, neighbors, teachers, doctors, employers, government agencies, community service agencies, etc.

The person for whom the planning is being held is primary in this process, but he may invite family and friends, teachers, counselors, community members, and others to plan with him and think creatively about the resources and supports that might be necessary to implement his plan. There are many tools to use for planning and these tools may be combined. A few examples are Personal Futures Planning, MAPS, I Have a Dream, The Other Way, A Good Experience, and Dream Cards. Information gathered from the use of one tool may be useful in one of the other planning processes.

Personal Futures Planning is one way to do Person Centered Planning. Think of Person Centered Planning as the toolbox holding all the tools that are person centered in their approach. There are many different planning tools that are person centered, and Personal Futures Planning is just one of these tools.

Person Centered Planning is an ongoing process used to support people with serious emotional disabilities (SED) to plan for the future.

Person Centered Planning & work Invites us to:

- ❖ find, develop, and showcase the gifts and interests of each person
- ❖ develop a vision that expresses these gifts and interests
- ❖ build a circle of support to make this vision become a reality
- ❖ develop and implement strategies designed to achieve this unique vision

Why Do Person Centered Planning

"Personal Futures Planning provides strategies to increase the likelihood that people with disabilities will develop relationships, be part of community life, increase their control over their lives, acquire positive roles in community life and develop competencies to help them accomplish these goals. Futures planning helps to clarify and implement these ideals, one person at a time." Beth Mount & Kay Zwenik

Person Centered Planning builds on a person's abilities and positive reputation, instead of trying to "fix" limitations.

When To Begin Person Centered Planning

Person Centered Planning begins when a person's need or goal is identified. There are tools for all age levels and abilities—even for those who do not communicate verbally!

Where Does it Take Place?

Person Centered Planning works best when meetings are held in informal settings. For example, people have held meetings in their homes, in restaurants, in library meeting rooms or conference rooms. There are also planning sessions held in classrooms, especially when the planning is part of a class curriculum, for example, a career class.

Who Should we be Involved in Person Centered Planning?

Most often, the person who is the focus of the planning invites the people he wants to include. Some people have helped from their family, teachers or friends to figure out whom to invite and to do the inviting. Some people send written invitations, but most use personal or phone contact.

What if the person can't think of anyone to invite?

It is important to meet with the person before the meeting to suggest some people to invite. Ask if they want to invite family, teachers, people they live with neighbors, etc. Also ask what they do after school or after work as this may help them to think of people to invite to the meeting.

It sometimes happens that they still have no one to invite. You may want to recommend some people they do not know, but who have the same interests they do or know about resources and may be able to participate in the meeting.

Some planning can be accomplished with a group of students working together to plan or doing parts of the planning with just one or two other people. There are students who are facilitating or leading their own meetings. There are also students who are facilitating meetings for other students.

How it works:

Step 1: Get to know the person by learning their "Positive Reputation" and "What is Most Important (and 2nd & 3rd Most Important)" for the person to have or not have in their life. Through this we learn about their relationships with people, things, places, animals, their routines, and their lifestyle pace.

- Gathering People Who are Willing to Listen and Help
  - Who listens when you talk about what's important to you?
  - Who keeps your needs and hopes from being ignored?
  - Who treats you with respect?
  - Who do you rely on and trust?
  - Who stands by you through thick and thin?
  - Who is willing to help you achieve your dreams?

Step 2: Use the knowledge and information learned in Step 1 to "Compare Their Current Life with Their Desired Life", and to support the person now and in the future. To do this, the team must: Identify "What Other People Need to

Know to Support the Person", "What Else Do We Need to Know", "Who Else Do We Need to Talk to".

- Honoring the Past and Describing the Present

Past

  - What major events have shaped your life?
  - What have been your major achievements?
  - What have been your major challenges?

Present

  - What does a typical day look like today?
  - What do I like and dislike about how I spend my day (e.g. relationships, work, free time)?

Step 3: Identify the person's and their family's "Dreams and Plans for the Future". This gives direction for planning for the person's life goals and IEP goals while they are still in school.

- Identifying Interests and Strengths
  - What things do you like to do?
  - What are your talents and strengths?
  - What aspects of your life do you enjoy the most?

Step 4: Make an "Action Plan" that is supported by the student's IEP and Transition Plan. The Action Plan is a broad plan covering all aspects of the person's life. The IEP and Transition Plan cover goals specific for school. These goals will help toward achieving the goals of the Action Plan.

- Creating a Vision of the Future Based Upon Hopes and Dreams
  - What new things would you like to be doing (3-5 years)?
  - How would you like to spend your "free" time?
  - Where would you like to live and who would you like to live with?
  - What type of work is of interest to you?
  - What other things would you like to accomplish in your life?

Step 5: The Action Plan is followed and the person has a life they want, with people who enjoy them, which leads to new interests and goals.

- Developing an Action Plan
  - Which parts of your future vision are most important to you?
  - What do you see yourself achieving during, the next year?
  - What type of activities of support might you need to achieve these goals and outcomes?
  - Who in your circle of support or others might help you indicate and achieve these activities?
  - When will these activities be completed and when will you meet again?

Step 6: As the person learns new things, has new interest, and new goals, the process continues with Step 1.

- Working the Plan
  - What parts of the plan went well?
  - What aspects of the plan did not work?
  - What parts of the plan should be continued?
  - What new steps should you add to the plan?
  - What other priorities do you want to address?
  - How will you address these priorities, who will help, and when will the tasks be done?
  - When will you meet again and who will facilitate

Is the information from the meeting confidential? Although people have asked this question, this has never surfaced as a major or controversial issue. People with whom the planning is being done agree to the "list of participants" and skilled facilitators recommend that any issues that may be confidential should be discussed at another time. Facilitators should talk to the person who is planning in advance of the meeting to determine if there are any issues that he may not want discussed.

Implementing the plan is often the hardest part of Person Centered Planning, but there are strategies that people have been using that seem to work so that the steps on the Action Plan get implemented. It is, of course, important that the person, and their family and advocates, when it is a person with a more severe cognitive disability, participate in the meeting and agree with the plan.

Following are some ideas:

- Incorporate the plan into the Individualized Education Program (IEP) or Individualized Written Rehabilitation Plan (IWRP) with specific goals and objectives.
- Designate one person to be the "point person" to whom others can check in.
- Hold follow-up meetings.
- Suggest that people "partner" with someone else to accomplish the activity.
- Suggest the student use a Day Timer, other calendar or checklist.
- Embed the follow along activities into a career class or Job Club.

System Centered	*Example*	**Person Centered**	*Example*
Focus on Labels	*A 17 year old with mental retardation*	See People First	*A person with a love of sports*
Emphasis on Deficits		Search for Gifts	
Use of "Tests"	*Assessments indicate he is a behavior problem*	Spend Time Together	*He is well connected in his community*
Focus on Changing "Negative Behavior"		Focus on Increasing Positive Experiences	
Focus on Segregated Service Options	*He is unemployable*	Focus on Valued Roles in the Community	*He has a committed support network and interested in employment*

Corporation, talks about the student with severe disabilities who wanted to be an astronaut, but it turned out what he really wanted was to wear a uniform. In other words, it is important to look for some next steps or the pieces of the dream that can be realized.

If someone wants to own and manage a coffee shop, she will first need to take at class at the community college about running a business, meet with people who do similar work, etc. People should not jump to the immediate conclusion that a person's dreams are unrealistic.

ACTIVITY:

Decorate a paper doll cut out with stickers, material, yarn, lace, etc. Think about what reflects the interests, talents and strengths of your youth.

R E S O U R C E S

WHERE AM I GOING? How will I get there?
A guide to creating your Future through transition planning
Distributed by Hawaii State Council on Developmental Disabilities and
Statewide Independent Living Council of Hawaii

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3. *Oregon Transition Systems Change Project, Commonly Asked Questions About Person Centered Planning, Revised September, 1995*

Person-Centered Planning - Summary Checklist

- ✓ My circle of support includes people who care about me, listen to me, and want to help.
- ✓ The hopes and dreams my circle of support identifies truly reflect MY vision for the future.
- ✓ My hopes and dreams for the future are based upon my talents, interests, preferences, and support needs.
- ✓ Planning meetings are held in a location that is comfortable to me.
- ✓ Everyone in my circle of support is involved in some meaningful way.
- ✓ I have people in my circle of support who are well connected in the community.
- ✓ My hopes and dreams are based upon goals I have for myself during the next 3 – 5 years.
- ✓ My transition plan's annual outcomes reflect my hopes and dreams in my person centered plan.
- ✓ My person centered plan includes actions steps, identifies who will help and be responsible, and includes timelines.
- ✓ My circle of support has discussed how often to meet and scheduled follow-up meetings.
- ✓ A facilitator has been identified for my circle of support.
- ✓ I feel I am making progress toward reaching my hopes and dreams.

CREATING "YOUR" WORLD!!

"Never doubt that a small group of thoughtful committed citizens can change the world; indeed it's the only thing that ever has."

Margaret Mead

SECTION 3: EDUCATION

April, 2002

The IEP for Transition-Aged Students

As a parent of a student with a disability you are probably concerned about your son or daughter as he or she makes the transition from the structured environment of school to the post-school world and all of the difficult life choices that entails. The services and supports your student needed in school may continue to be needed when he or she leaves school to pursue postsecondary education, job training, work, personal and social relationships, involvement in the community, and independent living.

From the time your child begins receiving special education services; his or her Individualized Education Program (IEP) guides his or her education. During the transition years, your son or daughter's IEP must contain specific transition services defined by The Individuals with Disabilities Education Act Amendments of 1997 (IDEA) regulations. The transition plan will lay the path toward your child's young adulthood. It must reflect his or her choices, preferences, and needs in the areas of education and training, employment, adult living arrangements, and community experiences. IDEA requires that parents and students be involved in all aspects of transition planning and decision making. To participate effectively, and to ensure that your student receives appropriate educational services, it is important that you and your son or daughter become familiar with the transition requirements of IDEA. Parents, students, educators, and community service providers must work together to support the student in planning for and achieving his or her adult goals.

IDEA Transition Requirements

IDEA requires that transition planning begin at the earliest age appropriate. For each student with a disability,

beginning at age 14 (or younger, if determined appropriate by the IEP team), the IEP must include a statement of the student's transition service needs that focuses on the student's course of study (such as advanced academic courses, technical training, or intensive employment preparation). Thus, beginning at age 14, the IEP team, in identifying annual goals and services for a student, must determine what instruction and educational experiences will help the student prepare for the transition from school to adult life. For example, if a student's transition goal is to secure a job, a transition service need might be enrolling in a career development class to explore career options and specific jobs related to that career. A statement of transition service needs should relate directly to the student's goals after high school and show how planned activities are linked to these goals.

The law requires that the IEP team begin no later than age 14 to address the student's need for instruction that will assist him or her in preparing for transition. Beginning at age 16 (or younger, if determined appropriate by the IEP team), the IEP must contain a statement of needed transition services for the student, including, if appropriate, a statement of interagency responsibilities. This includes a coordinated set of activities with measurable outcomes that will move the student from school to post-school activities.

The IEP must be updated annually or more often when needed. If the student is not making expected progress toward the annual goals and in the general curriculum, the team must meet and revise the IEP. Schools must report to parents on the progress of a child with a disability at least as frequently as they report on the progress of nondisabled children. Progress reports can help determine whether or not revisions to the IEP are needed.

According to IDEA Section 300.29---

(a) Transition services mean a coordinated set of activities for a student with a disability that:

(1) Is designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation.
(2) Is based on the individual student's needs, taking into account the student's preferences and interests;
(3) Includes:
(i) Instruction; (ii) Related services; (iii) Community experienc3es; (iv) The Development of employment and other post-school adult living objectives; and (v) If appropriate, acquisition of daily living skills and functional vocational evaluation.

(b) Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

The IEP Transition Team

Transition planning works best when students are actively involved. Family members and other adults also play important roles in this long-term planning. Teachers, administrators, and support agencies work with the student and family to reach the goals.

The IEP transition team relies on data from many sources to make decisions. Assessments, observation, testing, medical evaluation, and family history may be used to determine eligibility for adult services. Continued eligibility for services likewise relies on reevaluation and input from teachers and family.

All the professionals who work with the student must be knowledgeable about the student's IEP. They must understand their responsibilities and the specific accommodations, modifications, and supports that must be provided for the student in accordance with the IEP. This means that the IEP must be accessible to each of the student's teachers and all other service providers who implement any portion of the IEP, even if they do not attend the transition IEP meetings (for example, guidance counselors, vocational educators, social workers, psychologists). The IEP transition team involves the participation of several individuals, which may include the students, parents/guardians, general and special education teachers, related services personnel, counselors, administrators, adult service provide3rs, employers, postsecondary personnel, and other personal and professional support networks. The following is a description of the roles of the key individuals involved in the transition planning process.

Students

Students, no matter what or how significant their disability may be, are the most important people involved in transition. They should be as actively engaged as possible in all aspects of their transition process. The IEP team must specifically invite the student to attend any IEP meeting in which the team will be considering transition service needs or needed transition services. The transition planning process should be done with, not for the student. The student's IEP transition plan must be based on his or her individual needs, choices, and preferences with goals that reflect what the student is interested in doing now and what he or she will want and need when high school is finished. Preparing together for IEP meetings gives students and parents the opportunity to identify and discuss the student's goals for the future. If the student does not attend, schools must ensure that the student's preferences and interests are considered when developing the IEP transition plan.

Parents

Parents know their child better than anyone else and will be the one constant factor throughout their child's transition from school to adulthood. Their commitment to the IEP transition team is the key to making their child's transition to adult living a successful one. They bring a wealth of information about their child, which has great significance when developing a plan for transition. Parents provide knowledge about their child's interests and medical history, as well as about their child's behaviors at home and in the community. Their observations, along with the expression of family's values, provide the transition IEP team with a greater understanding of what services may be necessary and appropriate. Parents must be invited to IEP transition meetings and informed prior to the meeting that the discussion will involve transition issues. After the IEP is developed, parents must be given a free copy of their child's IEP without having to request it. If the student has reached the age of majority, the student can invite parents to attend, but the school is not required to invite the parents or guardians.

Special Education and General Education Teachers

IDEA requires at least one special education teacher or provider of the child to be a member of the IEP transition team. The team must also include at least one general education teacher of the child if the student is or may be participating in general education. The entire IEP team determines what services the student needs, such as positive behavioral interventions, supplementary aids, program modifications, assistive technology devices and services, and support for the teachers who serve the student.

Other School Personnel

IDEA requires a representative from the school district who is knowledgeable about the availability of resources of the public agency to attend the IEP meetings. The person must

be qualified to provide or supervise the provision of specially designed instruction to meet the unique needs of children with disabilities and be knowledgeable about the general curriculum. When tests, assessments, or new evaluations are being discussed, someone who can interpret what the results say about the student's instructional needs must be at the meeting.

Other Service Agencies

The student's IEP should include any needed transition services from outside agencies, such as vocational rehabilitation, county services, and postsecondary programs. Adult agencies whose services link school experiences with employment, future education or training and independent living opportunities should be invited to IEP transition meetings. These personnel could include representatives from residential facilities, mental health workers, county case managers, vocational rehabilitation counselors, or past or current employers. This is a critical component of transition planning. Many public and private agencies that offer adult services have eligibility criteria and waiting lists. The procedures used in each adult service system differ from school procedures. Some services from these agencies can begin before the student graduates. A smooth transition to adult services is more likely to occur if representatives from adult agencies are included in the transition IEP as early as possible.

If an outside agency fails to provide the service agreed to in the IEP, the school must call a meeting to identify alternate strategies to meet the transition objectives set forth in the IEP. IDEA does not relieve a participating adult agency of its responsibility to provide or pay for any transition services it would otherwise provide to people with disabilities who meet the agency's eligibility criteria.

Other Individuals

Parents may invite anyone with knowledge or special expertise regarding the child to be on the IEP team. Such persons may be a friend or relative, an advocate, or an employer. IDEA regulations provide that the person who issues the invitation determines whether that individual has knowledge or expertise that may be helpful in the IEP meeting. Parents, the student, and the school may invite whomever they choose.

What is the difference between the regulations at age 14 and at age 16?

- At age 14 planning must start. The student's post school goals should be developed and transition service needs identified. The needs may include a course of study and a year-by-year plan to achieve goals after graduation. The IEP team must determine what instruction and educational experiences will help the student prepare for transition from high school to post school life.

- By age 16, the needed transition services must be implemented. (NOTE: Some states have regulations that implement transition services at age 14 rather than 16.) Services could include instruction and related services, community experiences, vocational evaluation, employment, and other activities involved in adult living. A statement of interagency responsibilities should be included as well as needed links to other agency services. The IEP should be updated at least annually. The IEP team should also monitor the student's high school program to be sure the student completes all graduation requirements that are identified as appropriate in the student's IEP.

Special Factors for the IEP Team to Consider

The regulations [Section 300.346(a)(2)] also require that special factors be considered in the following areas:

- Behavior that Impedes Learning. In the case of a child whose behavior interferes with his or her learning or that of others, consider appropriate strategies and supports, including positive behavioral interventions, to address that behavior.
- Limited English Proficiency. In the case of a child with limited English proficiency, consider the language needs of the child as those needs relate to the child's IEP.
- Braille Needs. In the case of a child who is blind or visually impaired, provide for instruction in Braille unless the IEP determines that it is not appropriate for the child.
- Communication Needs. Consider the communication needs of the child, and in the case of a child, who is deaf or hard of hearing, consider the child's language and communication needs and opportunities for communication with others, along with the full range of needs.
- Assistive Technology. Consider whether the child requires assistive technology devices and services.

Conclusion

For 25 years, IDEA has been an important law for students receiving special education and related services. As a parent, you can do much to help your child with a disability move through their transition years. You can become familiar with the federal regulations and the procedures used in your state and school district. Appropriate transition services will enable your student to develop the skills he or she needs for independent living. With knowledge of IDEA, you and your son or daughter can become stronger self-advocates, and you can help your young adult develop skills needed for the future.

(This parent brief is produced by the National Center on Secondary Education and Transition (NCSET) and PACER Center.)

Section 504/Americans with Disabilities Act – The Other Service Option

What is Section 504?

Section 504 is often referred to as the first civil rights act for individuals with disabilities. It applies to parents, employees, and other individuals with disabilities.

Definition:

1st Prong: The individual has a physical or mental impairment that substantially limits one or more of a persons major life activities: walking, seeing, working, breathing, hearing, self care, learning, and speaking.

2nd Prong: Has a record of such impairment. Examples: persons who have histories of mental or emotional illness, drug addiction, alcoholism, heart disease, cancer, etc., and students who have received special education.

3rd Prong: Is regarded as having such impairment. This is when other people's attitudes and perceptions can create barriers for individuals with disabilities.

Who is eligible for Section 504?

- Every person or student eligible for Section 504 WILL NOT necessarily be eligible for special education, BUT

- Every person or student eligible for special education IS also protected under Section 504.

THERE IS NOTHING AS UNEQUAL AS THE EQUAL TREATMENT OF UNEQUALS.

Section 504 Guidelines and Implementation

- If the student is eligible under Section 504, the team determines accommodations and/or services that will enable the student to benefit from his/her education.
- The school staff makes the necessary accommodations to allow for the student's disability. Parents **should** be consulted and given opportunities for input. The accommodations and/or services are then implemented.

Section 504 Grievance Procedure

- Requires a grievance procedure to deal with the discrimination issues. *(Special Education grievance procedure is not required. A complaint can be filed with the school.)*

WHO IS THE PARENT?

PARENT means a natural or adoptive parent, a guardian, a person acting as a parent, or a surrogate parent who has been appointed.

UNLESS STATE LAW PROHIBITS, A State may allow a foster parent to act as a parent if parental authority to make educational decisions has been extinguished, and the foster parent:

- Has an ongoing long-term parental relationship with the child
- Is willing to make educational decisions
- Has no interest that conflicts with the interests of the child.

Federal Law

§300.20 Parent.

(a) **General**. As used in this part, the term parent means –

(1) A natural or adoptive parent of a child;
(2) A guardian but not the State if the child is a ward of the State;
(3) A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare); or
(4) A surrogate parent who has been appointed in accordance with §300.515.

(b) **Foster parent**. Unless State law prohibits a foster parent from acting as a parent, a State may allow a foster parent to act as a parent under Part B of the Act if—

(1) The natural parents' authority to make educational decisions on the child's behalf has been extinguished under State law; and
(2) The foster parent—
(i) Has an ongoing, long term parental relationship with the child;

(ii) Is willing to make the education decisions required of parents under the Act; and
(iii) Has no interest that would conflict with the interests of the child.

WHAT IS A SURROGATE PARENT?

A Surrogate parent is a person appointed to represent a child with a disability in special education planning when:

- No parent can be identified
- No parent can be located
- A child is a ward of the State

The surrogate:

- Is not an employee of the SEA or LEA, or agency involved in the education or care of the child.
- Cannot have a conflict of interest
- Has knowledge and skills.

Federal Law

§300.515 Surrogate parents.
(a) **General.** Each public agency shall ensure that the rights of a child are protected if –
(1) No parent (as defined in §300.20, previous page) can be identified;
(2) The public agency, after reasonable efforts, cannot discover the whereabouts of a parent; or
(3) The child is a ward of the State under the laws of that State.

(b) **Duty of public agency**. The duty of a public agency under paragraph (a) of this section includes the assignment of an individual to act as a surrogate for the parents. This must include a method –

(1) For determining whether a child needs a surrogate parent; and

(2) For assigning a surrogate parent to the child.

(c) **Criteria for selection of surrogates**.

(1) The public agency may select a surrogate parent in any way permitted under State law.

(2) Except as provided in paragraph (c)(3) of this section, public agencies shall ensure that a person selected as a surrogate –

(i) Is not an employee of the SEA, the LEA, or any other agency that is involved in the education or care of the child;

(ii) Has no interest that conflicts with the interest of the child he or she represents; and

(iii) Has knowledge and skills that ensure adequate representation of the child.

(3) A public agency may select as a surrogate a person who is an employee of a nonpublic agency that only provides non-educational care for the child and who meets the standards in paragraphs (c)(2)(ii) and (iii) of this section.

(d) **Non-employee requirement; compensation**. A person who otherwise qualifies to be a surrogate parent under paragraph (c) of this section is not an employee of the agency solely because he or she is paid by the agency to serve as a surrogate parent.

(e) **Responsibilities**. The surrogate parent may represent the child in all matters relating to—

(1) The identification, evaluation, and educational placement of the child; and

(2) The provision of FAPE to the child.

Keeping Records – A Journal of Your Child's Progress

Adapted from "For Parents of Exceptional Students" – Department of Education, Tallahassee, Florida

"The first thing I always say to other parents when they begin to have problems is, 'You have got to keep good records – almost a daily long.' I keep a little notebook in my purse to write down the problems with my son – to write the good things he does – to write down who I contacted in the system. I write their names, their phone numbers, what they tell me, when they will call back, when they don't – that way I have data.

Sometimes it's not easy – when you are under stress and duress, it isn't easy. But if you don't keep track, no one will. It is critical. Documentation may seem like another burden, it helps keep your head straight, keeps you organized. In the end it will be less of a burden."

ACTIVITY:

File folders or 3-ring binders to bring together pertinent information to be used in organizing important information to be used in preparing and writing effective Individual Education Plans. Sections should include: General Information, Copies of Educational Plans, Timeline History, General School Information, Medical Records, School Evaluations/Testing, Report Cards, Phone Log/Written Correspondence, Diagnosis/Medication Fact Sheets, Agency Information, Support Group Information, and Miscellaneous Resources.

Evaluation Process

1. Parent makes a written request for special education testing to be done.
2. School has parent sign Permission to Evaluate Form. Once this form is signed the school has 30 school days to begin the testing process, this should include classroom observations on three separate occasions and parent and teacher evaluations.
3. When testing is complete, the school should call the parents and arrange to meet with them to go over the testing. Prior to this meeting the parents should receive a Notice of Meeting letter which should include the date, time and place of the meeting, as well as a list of attendees. At the meeting the school district must give the parents a copy of their Parents Rights.

   Based on test results, the student may be qualified for Special Education and related services and an IEP will be written.

   If the child does not qualify for Special Education but still needs some help in school a 504 Plan may be written at this time.

4. An IEP needs to be rewritten **at least** every 12 months. It can and should be revised if any of the following apply:
   a. A student moves from one school to another
   b. A student is moved from one placement to another, for example, from a regular education classroom to a self-contained classroom.
   c. There need to be changes to the amount of resource time, related services, etc.
   d. The plan does not seem to be working for the student
   e. The student meets the goals outlined on the IEP
   f. Any member of the team feels the IEP needs to be revised.

Before each IEP meeting the parent should again receive a Notice of Meeting as mentioned above. At the meeting they should again by given a copy of their Parent Rights.

5. The testing should be repeated every three years. Most tests are invalid if they are repeated at a shorter interval.

Conference Planning – IEP Parent tips:

- ✓ Ask for and review evaluation data before the IEP conference.
- ✓ Know who will attend, and who you will bring
- ✓ Gather information to share, including medical or other assessments
- ✓ Write down your questions
- ✓ Write down your priorities
- ✓ Let someone know if the meeting time does not work for you.
- ✓ Depending on extent of disability, some students will have until their 22nd birthday to accomplish transition goals.

THE TEN BASIC STEPS TO TRANSITION PLANNING

1. Survey youth and/or parent-guardian transition needs and preferences
2. Develop a transition team able to help the youth achieve desired goals
3. Discuss the youth's postsecondary goals with the transition team
4. Identify transition services needed to develop or achieve these goals
5. Assign responsibility for each transition service and set target dates

6. Establish IEP objectives for major transition service and set target dates
7. Follow-up with persons assigned to provide transition services as needed
8. Re-convene the transition team if services cannot be provided as planned
9. Evaluate the statement of needed transition services (ITP) annually
10. Revise the plan and reassess youth needs and preferences, if necessary.

Adopted from JoAnnWelker, Findlay City Schools and Rene Phillips, Southwester City Schools

EXITING THE SCHOOL SYSTEM

Graduation Options:

- (Regular) High School Diploma
  - Basic High School Diploma
    - Meet all USOE and LEA course requirements
    - Pass all 3 subtests of the UBSCT
  - Alternative Completion Diploma
    - Meet all USOE and LEA course requirements
    - Document at least 3 attempts to take and pass all subtests of the UBSCT, and does not pass all subtests
- Certificate of Completion
  - Does not meet all USOE and LEA course requirements
  - Can not document at least 3 attempts to pass all subtests of the UBSCT
  - Has completed the senior year in high school
  - Is exiting the school system

School district responsibility for special education services ends when:

- The student graduates with a regular high school diploma, or
- The student reaches the 22nd birthday.
    - Birthday between the beginning of school and Dec. 31, exit at the beginning of the school's winter holiday
    - Birthday between Dec. 31 and the end of the school year, exit at the end of the school year.

PARENTING POST-SECONDARY STUDENTS WITH DISABILITIES: BECOMING THE MENTOR, ADVOCATE, AND GUIDE YOUR YOUNG ADULT NEEDS

The importance of involving parents in the education of elementary and secondary school students is widely encouraged. In fact, federal law—the Individuals with Disabilities Education Act (IDEA)—has created a process to involve parents in the education of their children with disabilities. Once youth with disabilities graduate from high school, however, resources and guidance to help parents with this challenging new phase of parenting become difficult to find. Yet, parents continue to be important role models and guides for their young adult sons and daughters. For students with disabilities, parents may be a key part of the support network they need to succeed in the postsecondary environment.

Experts on human development consider late adolescence a very important time of life for all individuals. It is a "launching period" when parents help youth develop the skills they will need as adults. This "launching" process does not end because a student graduates from high school, reaches the legal age of adulthood ("age-of-majority"), or enrolls in a college or other training program. New and important parenting issues continue to arise as young adults grow up.

Parents as Mentors

Although parents of young adults with disabilities no longer have the same authority they once had in the lives of their children, they can provide guidance and support through a mentor or advisor role. Mentors teach, challenge, and support their protégé. A parent's mentoring relationship must be based on an underlying trust and respect for one's child as someone capable of learning how to manage his or her own life.

Whether a student has a disability or not, the greatest challenge for parents of post secondary students is learning when and how to be supportive while still encouraging self-determination and independence. It may require a giant leap of faith for parents to trust that their sons and daughters have all the resources they need to deal with the unfamiliar challenges of post secondary education. Nonetheless, post secondary schools treat students as legal adults. It is important for parents to do all they can to reinforce their faith in their child's ability to manage life at school.

Effective mentoring takes clear communication skills. Parents may find it helpful to learn about and practice these skills so they can use this technique consistently and well. This approach in depth in the book *Don't Tell Me What to Do—Just Send Money: The Essential Parenting Guide to the College Years* by Helen E. Johnson and Christine Schelhas-Miller.

Parents as Advocates

No matter how much parents respect and trust their children, it is difficult to let them learn from mistakes when the consequences are serious. Although parents must be careful not to "take over" the problems of their young adult sons and daughters, situations may arise when parents need to take a more active role.

Young adults often unload everyday worries on parents and then go on about their lives. Parents must distinguish between these kinds of situations and more serious circumstances—such as substance abuse, mental or physical illness, other threats to their child's health or safety, serious financial issues, and, for youth with disabilities, discrimination.

Once parents decide to act, their first involvement should always be directly with their son or daughter – to whom parents can provide resources, information, and emotional support. Parents may also want to contact the post-secondary program to ask for help assessing the situation. If the child is in college, the Disability Services Offices is a good place to start. Other offices may also be appropriate depending on the nature of the concern. These include health services, the Dean of Students, ADA coordinators, and Section 504 coordinators. Many colleges and universities also have a parents' program office.

Parents of students with disabilities who are concerned about their child's educational program or academic accommodations can draw on their experience as special education advocates. However, they will need to understand the differences between special education laws, the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act. Parents may encounter some resistance to their involvement. Post secondary professionals are not used to working with parents and may see it as inappropriate or even harmful. In fact, school staff cannot legally share information with parents without a student's written permission.

Young adults of legal age are responsible for making their own decisions even in serious situations. Unless parents are the legal guardians of their adult child, their role is to support their son or daughter as the young adult solves his or her problems. Parents may only need to help them gather information and understand their options. Ultimately, a student's maturity, cultural values, and other individual

characteristics will determine the kind of involvement and family support that is appropriate and helpful for each student.

So What's a Parent to Do?

The post-secondary years provide students with both new freedoms and new responsibilities. Many students are living away from home for the first time or are new to making personal decisions on their own. Parents are naturally concerned about the safety, health, and social adjustment of their sons and daughters. Disability-related issues can make this an even more challenging time for students and parents. However, there is help available.

Materials for parents of college students, such as the previously mentioned book by Helen E. Johnson and Christine Schelhas-Miller, can be found on the shelves of local bookstores and libraries. Several web sites have also been created for the parents of college students. Many colleges and universities, for example, provide tips for parents on their web sites. Unfortunately, these resources do not address the many unique challenges faced by students with disabilities and their families.

Information developed specifically for the parents of high school students with disabilities, on the other hand, does not cover parenting issues during the college years. These materials generally try to help parents prepare youth for the transition to post-secondary education, find financial aid, and learn about ADA and Section 504. The benefits of family support may be mentioned, but what this support looks like at the post-secondary level is not described. In fact, an emphasis in recent transition literature on overprotective parenting and learned helplessness has given some parents and educators the mistaken impression that parent involvement is wholly undesirable at the post-secondary level.

Although not widely available, a handful of recent studies confirm the value of the supports parents provide at the post-secondary level and indicate that active parent involvement can foster, rather than hinder, self-determination. Additional studies and research-based guidance on these issues is needed to help parents effectively support their sons and daughters with disabilities in the post-secondary years.

RESOURCES

- PACER Center, http://www.pacer.org
- National Center on Secondary Education and Transition, http://www.ncset.org/
- National Center for the Study of Postsecondary Education Supports, http://www.rrtc.hawaii.edu/
- HEALTH Resource Center, http://www.health.gwu.edu
- National Information Center for Children and Youth with Disabilities, http://www.nichcy.org/
- "Understanding the Transition to College," (George Washington University site): http://gwired.gwu.edu/counsel/counsel.php?id=1935
- College Parents of America, http://www.collegeparents.org/
- ParentsAssociation.Com "College Central", http://www.parentsassociation.com/college/index.html
- Higher Education Center for alcohol and Other Drug Prevention, http://www.edc.org/hec/parents/

For **individualized information, advocacy and referral services** contact:

- Allies with Families, 450 E. 1000 No. #311, North Salt Lake, Utah, 84054, (801) 292-2515, toll free 1-877-477-0764, FAX (801) 292-2680, allieswithfamilies.org
- Utah Parent Center,
- Centers for Independent Living, http://www.virtualcil.net/cils/

(This parent brief is produced by the National Center on Secondary Education and Transition (NCSET) and PACER Center.)

SECTION 3:
ACCOMMODATIONS FOR STUDENTS WITH DISABILITIES IN HIGH SCHOOL

Issue: Fewer students with disabilities in middle schools and high schools use accommodations than students with disabilities in elementary schools.

Defining the Issue

Accommodations are changes in materials or procedures that provide access to instruction and assessments for students with disabilities. They are designed to enable students with disabilities to learn without the impediment of their disabilities, and to show their knowledge and skills rather than the effects of their disabilities. While there is some controversy surrounding terminology (e.g., accommodations vs. modifications) and about the appropriateness of certain assessment accommodations (Fuchs & Fuchs, 1999; Thurlow & Wiener, 2000), in general there is an acceptance of the need for some changes in instruction and assessment for students with disabilities. Examples of common instructional assessment accommodations are shown in Table 1.

There is nothing about students with disabilities, or about instruction and assessment that would suggest that the number of students with disabilities using accommodations should change as they progress through school. Are there other things occurring that might affect the number of students receiving accommodations? Are there constraints on the provision of accommodations that can be alleviated to ensure that all middle school and high school students who need accommodations receive them?

What We Know

Legal Considerations:

When the Individuals with Disabilities Education Act (IDEA) was reauthorized in 1997, accommodations (and modifications) in administration were addressed. In Section 300.347 on Individual Education Program (IEP) content, IDEA states that there needs to be –

…a statement of the program modifications or supports for school personnel that will be provided for the child –

- To advance appropriately toward attaining the annual goals;
- To be involved and progress in the general curriculum;
- To participate in extracurricular and other nonacademic activities; and
- To be educated and participate with other children with disabilities and nondisabled children in the activities described in this section

Section 300.342 of IDEA also states that the IEP must be in effect at the beginning of each school year so that each teacher and provider is informed of "the specific accommodations, modifications, and supports that must be provided for the child in accordance with the IEP.

In addition to addressing accommodations and modifications in instruction, the Final Regulations for IDEA state that for assessments, the IEP for each child with a disability must include a statement of:

Any individual modification in the administration of state or district-wide assessments of student achievement that are needed in order for the child to participate in the assessment.

The term "accommodations" is also used in Section 300.138, which indicates that –

The state must have on file with the Secretary i9nformation to demonstrate that – (a) Children with disabilities are included in general state and district-wide assessment programs, with appropriate accommodations and modifications in administration, if necessary.

None of the language of the law indicates that the number of students with disabilities who need accommodations will change as students get older and move from one level of schooling to the next, although the specific accommodations that students need may change over time (Elliott & Thurlow, 2000).

Table 1. Examples of Instructional and Assessment Accommodations*

Instructional Accommodations	
Materials/Curriculum	◆ Alternative assignments ◆ Substitute materials with lower reading levels ◆ Fewer assignments ◆ Decrease length of assignments ◆ Copy pages so students can mark on them ◆ Provide examples of correctly completed work ◆ Early syllabus ◆ Advance notice of assignments ◆ Tape-recorded versions of printed materials
Methods/Strategies	◆ Highlight key points to remember ◆ Eliminate distractions by using a template to block out other items ◆ Have student use a self monitoring sheet ◆ Break task into smaller parts to do at different times ◆ Use study partners whenever reading or writing is required ◆ Secure papers to work areas with tape or magnets ◆ Present information in multiple formats ◆ Use listening devices
Assessment Accommodations	
Setting	◆ Study carrel ◆ Special lighting ◆ Separate room

	◆ Individualized or small group
Timing	◆ Extended time ◆ Frequent breaks ◆ Unlimited time
Scheduling	◆ Specific time of day ◆ Subtests in different order
Presentation	◆ Repeat directions ◆ Larger bubbles on multiple choice questions ◆ Sign language presentation ◆ Magnification device
Response	◆ Mark answers in test booklet ◆ Use reference materials (e.g., dictionary) ◆ Word process writing sample
Other	◆ Special test preparation techniques ◆ Out of level test
Reprinted with permission from Box 3.2 and 3.3 in Thurlow, M.L. Elliott, J.L., & Ysseldyke, J.E. (1998). Testing students with disabilities: Practical strategies for complying with district and state requirements. Thousand Oaks, CA: Corwin Press.	

Definitional Considerations

"Accommodation" is just one of many terms that have been used to indicate a change in instructional or assessment materials or procedures. Another frequently used term, "modification," is generally (but not always) used to refer to a change in which scores produced are invalid or otherwise not comparable to other scores. IDEA uses both "accommodation" and "modification in administration," but intends that the terms be viewed as comparable and inclusive. As stated in a memorandum from the Office of Special Education Programs (OSEP), "the terms as used in the statute and regulations are not intended to correspond with the evolving usage of these terms in the field of assessment …. 'Modifications in administration' should be viewed as a general term that would include both accommodations and modifications, as they are commonly used in assessment practice" (Heumann & Warlick, 2000, p.8).

What We Don't Know

We do not yet know what is happening in the majority of situations in which accommodations are being used. Most of the data that we do have on use of accommodations is from assessments, usually state-level tests. Even so, we have a relatively limited number of states able to provide data on the use of accommodations by students receiving special education services. However, given these limited data, we do not yet have a real sense of why there are differences. The survey data of Jayanthi et al. (1996) suggests that teachers at different grade levels do have different perceptions of the helpfulness and ease of administering many accommodations. Do these different perceptions translate into what is selected for students during assessments?

Is there any reason to believe that students with disabilities who are in the upper grade levels have less need for accommodations? Could it be that those students who most need

accommodations are the students who have already dropped out of school, and therefore the percentages of students using accommodations drops simply because the ones left need fewer accommodations? Could it be that teachers' perceptions influence their willingness to provide accommodations to students who may actually need them? We do not know the answers to these questions.

Perhaps most important is the question of how what we know (and do not know) relates to the accommodations that students receive during instruction. Most assessment guidelines speak of the need for there to be an alignment between assessment accommodations and instructional accommodations (Elliott & Thurlow, 2000; Thurlow, House, Boys, Scott, & Ysseldyke, 2000). If students with disabilities are receiving fewer accommodations during assessments in the upper grades, does this also mean that they are receiving fewer accommodations during instruction? Is this justified? Do teachers at the upper grade levels face logistical barriers that make providing accommodations nearly impossible unless the student simply cannot function without them?

The grades in which students with disabilities are involved in transitions planning are the same grades in which we see declining numbers of students using accommodations. Does that mean that students are less likely to be aware of their need for accommodations because they are not being built into transition plans? If they are not built in during transition planning, do students leave school without any idea of their accommodations needs? And if so, what impact does this eventually have on their success in their post secondary work or education?

What to Do Now

There clearly are many unanswered questions about the issue of declining percentages of students with disabilities receiving accommodations as they reach middle and high school. An important next step is to begin to answer some of the many related questions.

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(This parent brief is produced by the National Center on Secondary Education and Transition (NCSET) and PACER Center.)

Utah State Office of Education – Special Education Rules:

III.J. Transition Services

1. For purposes of these Rules, "transition services" means a coordinated setoff activities for a student with a disability that:

   a. Are designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation.

   b. Are based on the individual student's needs, taking into account the student's preferences and interests.

   c. Includes:

      (1) Instruction
      (2) Related services
      (3) Community experiences
      (4) The development of employment and other post-school adult living objectives.
      (5) If appropriate, acquisition of daily living skills and functional vocational evaluation.

   d. May be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

2. As used in these Rules, "participating agency" means a state or local agency other than the LEA responsible for the student's education that is financially and legally responsible for providing transition services to the student. Agency responsibilities for transition services are as follows:

   a. Any participating agency, including a state vocational rehabilitation agency, is not relieved of the responsibility to provide or pay for any transition service that the agency would otherwise provide to students with disabilities who meet the eligibility criteria of that agency.

   b. If a participating agency, other than the LEA, fails to provide the transition services described in the IEP in accordance with these Rules, the LEA shall

reconvene the IEP team to identify alternative strategies to meet the transition objectives for the student set out in the IEP.

III. Y. Termination of Services

Termination of special education/related services to a student with a disability constitutes a change in placement and is therefore subject to the notice requirements of Rule IV.D. Termination of services must be made through a team meeting held for reviewing or changing a student's IEP. Required participants in the meeting to consider termination of services are the same as in any IEP meeting, and include the student's parents. Discontinuation of special education services may be because:

1. The student no longer qualifies for special education services, as determined by the IEP team through the reevaluation process (Rules II.D., E., and F.).

2. The parent (or student of majority) refuses special education services. In this case, services are discontinued but the student is not declassified, and eligibility for services continues until the expiration of the three-year evaluation period. Such a refusal of service must be documented in writing and signed by the parent/guardian. If school personnel disagree with the decision of the parent to terminate special education, the LEA may request a due process hearing in order to allow the services to continue. (See Rule IV.I.)

IV.V. Transfer of Parental Rights at Age of Majority

1. Consistent with state law which applies to all students, when a student with a disability reaches the age of 18 (except for a student declared incompetent by the courts), the LEA shall provide any Notice required by these Rules to both the student and the parents, and all other rights accorded to parents under Part B of the IDEA and these Rules transfer to the student.

2. All rights accorded to parents under Part B of the IDEA and these Rules transfer to students over age 18 who are incarcerated in an adult or juvenile, state, or local correctional institution.

3. If a student with a disability is determined by the court not to have the ability to provide informed consent with respect to his or her educational program, the LEA shall establish procedures for appointing the parent, or if the parent is not available, another appropriate individual, to represent the educational interests of the student throughout the student's eligibility under Part B of the IDEA. The LEA shall use its surrogate parent procedures in order to implement this requirement. The parent still retains the right to any required notice, along with the student. All other rights accorded to parents under Part B transfer to the student.

4. A statement is required on the student's IEP, beginning at least one year before a student's 18th birthday, that the student and parents have been informed of their rights under Part B of the IDEA that will transfer to the student on reaching the age of 18, consistent with these Rules. The parent still retains the right to any required notice, along with the student. All other rights accorded to parents under Part B transfer to the student.

504 Accommodation Plan (to be reviewed at least annually

Date_____
Student_____Birthdate_____Grade_____School_____

Student Number_____ Disability_____

Eligibility for 504 Assistance (check all applicable areas)
☐ caring for one's self ☐ speaking ☐ performing manual tasks ☐ breathing ☐ walking ☐ learning ☐ seeing
☐ working ☐ hearing ☐ Other _____

Description of Needs	Accommodations Required Educational Staff	Action To Be Taken By Student	Parent/Guardian

Team signatures Position Date
_____
_____
_____

Annual Review
Team signatures Position Date
_____
_____
_____
___Continue ____Terminate ____Reevaluate

Comments_____

REFERRAL LETTER

Name: _____
Address: _____
_____
Phone: _____

Date: _____

To: (school)
_____

_____

_____

_____

Dear Sirs,

My child _____ is a student in _____ grade in your school, and I believe he is having problems which are interfering with his/her progress in school.

I am requesting that he/she be evaluated so that an appropriate school program can be provided.

Please notify me of any meetings held to discuss my child. I would like to attend those meetings. I also want to know when the evaluation will take place.

Thank you,

Sincerely,

cc: Director of Special Education
_____ School District

KEEPING RECORDS

TELEPHONE CALLS

Who? _____Date_____

Title_____Phone #_____

Notes _____

Need to follow up? Yes_____ No_____
If yes with whom? _____When? _____

Who?_____Date_____

Title_____Phone #_____

Notes _____

Need to follow up? Yes_____ No_____
If yes with whom?_____When?_____

Who?_____Date_____

Title_____Phone #_____

Notes _____

Need to follow up? Yes_____ No_____
If yes with whom?_____When?_____

KEEPING RECORDS
BEFORE THE IEP MEETING
OBSERVATION GUIDE

Name of Child_____Age_____

1. What things does our child do best?

At Home? _____

_____

At School?_____

_____

2. What problems does your child seem to have?

At Home?_____

_____

At School?_____

_____

3. How does your child feel about?

School?_____

Himself/Herself?_____

Other students?_____

4. What does your child do in their free time?_____

_____

5. What does your child dislike?_____

_____

6. How well does your child care for him/herself?_____

_____

_____

7. What kinds of things does your child do to help at home?_____

_____

_____

8. How well does your child listen and talk to you?_____

9. How well does your child follow directions?_____

10. Does your child have friends?_____

11. If so, how old are they?_____

12. What do they do together?_____

13. What does your child most need to learn in school?_____

IEP Questions to consider

- ☐ **Are my child's goals measurable?**
- ☐ **Does my child participate in the general curriculum all or part of the day?**
- ☐ **Does the IEP list the modifications, accommodations and other supports my child needs to succeed?**
- ☐ **Is the school expecting the kind of progress I thing my child should make?**
- ☐ **Is the expected progress enough for my child to meet graduation requirements?**
- ☐ **How often will my child's IEP goals be reviewed?**

KEEPING RECORDS
IEP MEETING

Did you get a notice about the meeting? Yes ☐ No ☐
If yes, date of notice _____# of days before the meeting_____

Did you get any other kind of notice? Phone call ☐ Visit ☐

Did you ask to change the date, time/place? Yes ☐ No ☐
If yes, were you able to make the change? Yes ☐ No ☐
Did you go to the meeting? Yes ☐ No ☐
If not, why not?_____
If no, did the school ask you to help with the IEP in some other way?_____

Who was present at the meeting?
Name_____Title_____
Name_____Title_____
Name_____Title_____
Name_____Title_____
Name_____Title_____
Name_____Title_____
Name_____Title_____
Name_____Title_____

Did your child attend the meeting? Yes ☐ No ☐

Was there a need for more than one meeting? Yes ☐ No ☐
If yes, give details_____

Were you and the school able to agree on the IEP? Yes ☐ No ☐
If no, what did you do?_____

Did you get a copy of the IEP? Yes ☐ No ☐

Keep a copy of the IEP in your file.

LETTER – REQUEST FOR INDEPENDENT EVALUATION

Name_____
Address_____
_____

Phone_____
Date_____

To: Director of Special Education
_____ School District
_____
_____

Dear Sirs:

My child _____is a student in _____ grade at _____school. My child has been evaluated by the school system. I disagree with parts of the evaluation and think that my child needs an independent evaluation. My reasons for this request are _____

I understand that this evaluation will be paid for by the school system.

Please answer this request in a letter. Thank you.

Sincerely,

cc: Principal
_____School

LETTER – REQUEST FOR AN IEP REVIEW

Name_____
Address_____
_____

Phone_____
Date_____

To: Director of Special Education
_____ School District
_____
_____

Dear Sirs:

My child _____is a student in _____ grade at _____school. Because of the changes I have seen in my child, I believe it is time to review the IEP and to revise it. I ask that a meeting be held as soon as possible. Please contact me so that we can set up a time to meet with the IEP at a time and place convenient to all.

Thank you for your help with this.

Sincerely,

cc: Principal
_____School

LETTER – REQUEST FOR COPIES OF SCHOOL RECORDS

Name_____
Address_____
_____

Phone_____
Date_____

To: The Principal
_____ School
_____
_____

Dear Sirs:

My child _____is a student in _____ grade at your school. I am requesting copies of all records kept on my child. Please inform me where the records are kept, the person I should contact to see them, and how to get copies. I understand that if I read something in the records that I do not understand, someone from the school system will explain it to me.

Thank you for your help with this.

Sincerely,

KEEPING RECORDS

THREE YEAR RE-EVALUATION

Date of Re-Evaluation_____Age_____

Reason for Re-Evaluation_____

_____

_____

What kinds of evaluations were done?_____

_____

_____

Where was the re-evaluation done?_____

Did you read the reports? Yes ☐ No ☐

Did someone explain the reports to you? Yes ☐ No ☐
If yes, who?_____When?_____

Do you have a copy of the reports? Yes ☐ No ☐

Keep copies of re-evaluation reports in your file.

Section 4: LEGAL ISSUES

Bobby's story…
Bobby is a 32 year old man who is mentally retarded but very high functioning and who looks normal. He has Bipolar Disorder with Schizo tendencies. Ten years ago, Bobby graduated from high school then went to a tech school. He was done with school by age 21 and lived with his mother. In the early 1990s, there wasn't much job placement or job coaching so he was on his own to find and hold a job. He didn't have a case manager or any mental health services to speak of. Bobby had behavioral problems and he wouldn't stay on his medication. His mother would try to help him but legally he was an adult and therefore, her hands were tied. She wasn't able to control any of his actions. Eventually Bobby ended up in a "half way type house" where other young people with behavioral problems lived. There was little to no supervision there. Bobby learned even more bad behaviors. He would steal, lie, pawn his belongings, empty his bank account to party, and was often physically violent. He would check out library books and not return them, ending up with hundreds of dollars of fines. He drank, ran around with unsavory people, and would smoke cigarettes, sometimes a pack an hour.

After about 7 years of floating around aimlessly in life not being productive and often being taken advantage of by others, Bobby was put into a group home setting. Because he didn't have a guardian, the group home personnel could not stop him from doing any of the bad things that he did because according to the law, he was an adult and could make his own decisions. They had to stand by silently while he was hurting himself and others were using him for money, etc.

When Bobby was 29 years old, his mother decided that she couldn't let Bobby continue on his destructive path, so she talked to him about guardianship. He was totally against the idea, realizing that he wouldn't be able to do everything anytime that he wanted. After 3 long years of legal battles, many doctors' reports, and of Bobby doing many frightening things (which were documented), Bobby's mother was able to gain guardianship for Bobby.

Bobby has been stable for two months now. He takes his medication and has a legitimate job. He isn't allowed to leave the house without supervision and has no access to his finances. He still smokes but is only allowed one cigarette every 3 hours. He is beginning to live a productive life … finally.

What is this thing called Guardianship?

Guardianship is about who can legally make decisions for someone else. It has to do with the fact that when someone turns 18 he/she becomes a legally competent adult with full adult rights and legally has the ability to make his own decisions. This fact applies equally to all and there are no distinctions that might be made because someone has a disability. People with cognitive disabilities who turn 18 may lack the functional ability to make their own decisions in some areas of their lives. People like this might benefit by having some type of assistance with decision making. Options for a person who is relatively capable in decision making might include teaching and training, and advocacy. Stronger interventions which give someone else power to make decisions in the disabled person's behalf include power of attorney or other types of advance directives, bill paying services, or guardianship. Guardianship is the most restrictive of these measures and should be used only when there is no other way to support someone in decision making.

FIVE AREAS OF GUARDIANSHIP:

Medical
Habilitation
Educational
Residential
Financial

WHAT IS A LIMITED GUARDIANSHIP?

Limited Guardianship is providing care and supervision in the least restrictive form, by individualizing Guardianships so a person under the Guardianship keeps as many rights as possible. For example: Guardians are entitled to custody (where the person lives), consent to treatment (Medications

and Mental Health), and receive money or property for the individual.

Under a Limited Guardianship, the guardian may not have custody, but may be allowed to consent to treatment, and receive money and property.

Utah law states "The court shall prefer a limited guardianship and only grant a full guardianship if no other alternative exists. If the court does not grant a limited guardianship, a specific finding shall be made that nothing less than a full guardianship is adequate."

When Can An Adult Have A Guardian?

A guardian may be appointed by the court for a person who the court finds meets the definition of "Incapacitated Person" – Any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause except minority to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions.

What Power Does A Guardian Of An Adult Have?

Unless the court orders otherwise, the same powers, rights and duties that a parent has for an unemancipated minor (a child under the age of 18 and not married), except that a guardian is not liable to a third person for acts of the ward (incapacitated person) solely by reason of the parental relationship.

Why Should I Consider Guardianship?

Adult children who lack functional competence may benefit by having their parents become their legal guardians. This type of guardianship allows the parents to continue to perform in the parental role by making decisions in areas

where it might be difficult for their disabled adult child to do so. These areas might include medical decision making, financial management, program and educational decision making and residential placement issues, and other areas where a disabled person needs decision making support.

Guardianship is not something that should be taken lightly. It is a court process that awards some rights held by one person to someone else. It requires honesty, integrity and objectivity on the part of the guardian to support the ward in his/her wishes while at the same time acting in his/her best interests. A guardian is under jurisdiction of the court and may act in only the areas the court has defined.

Guardianship is not needed by everyone who is disabled and turns 18. Many individuals are capable of making appropriate decisions with little or no assistance. Careful consideration needs to be given to the needs of every disabled person before leaping into guardianship.

When Should I Start the Process?

Guardianship should be thought about by parents long before the youth's 18th birthday. The actual process of applying for guardianship should begin, at the earliest, between 3 to 4 months prior to the youth's 18th birthday. It can be done at any time in an adults' life.

Where Do I Start?

The legal steps to guardianship take place in the Probate Division of the District Court where the youth resides.

Who is Guardianship for?

A guardian may be appointed by the court for a person who the court finds meets the definition of "Incapacitated Person" – Any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause

except minority to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions.

How Do I Get It?

Guardianship Associates provides two options in pursuing guardianship – Attorney Representation and acting *"Pro Se"*.

Option 1: Attorney Representation
The cost of preparing a guardianship through the Guardianship office was $805 at the time of this writing, broken down as follows:

- Attorney for you $400
- Court filing fee $155
- Contribution to Guardianship Associates $50
- Attorney for the ward $200

What documents you need to bring with you:

- A letter from your child's doctor stating his/her diagnosis and that the doctor believes your child would benefit by having a guardian.
- A copy of your child's psychological evaluation that shows his/her diagnosis.

Be prepared to complete a questionnaire for the attorney's office – bring your address book!

Be prepared to spend approximately 1 hour and be prepared to ask all the questions you have about guardianship.

Option 2: Acting *"Pro Se"*
If parents wish to act "PRO SE" in their guardianship proceedings ("PRO SE" means to act as your own attorney).

The cost for acting PRO SE is $405.00 broken down as follows:

- Court filing fee $155.00 – **that is paid directly to the court and not to GAU**
- Contribution to Guardianship Associates $50.00
- Attorney for the ward $200.00

Guardianship Associates will provide a computer disk that has information necessary to file your own petition. This disk includes a sample guardianship petition that you can use to prepare your own petition. The value of acting PRO SE is that the parents or proposed guardians can avoid paying an attorney for their side of the guardianship. There is still a court filing fee and a fee for the attorney representation of the proposed ward. Guardianship Associates also asks for a $50 donation for training, information and assisting proposed guardians in obtaining representation for the proposed ward. Potential guardians should be prepared to tell the court why they want guardianship and be prepared to answer any of the judges questions.

R E S O U R C E S

The Disability Law Center
At the Community Legal Center
205 North 400 West
Salt Lake City, Utah 84103
1-800-662-9080 (Voice) or 1-800-550-4182 (TTY)
801-363-1437 (Fax)

Services are statewide and free of charge to all eligible individuals in Utah.
Contact: info@disabilitylawcenter.org

Guardianship Associates

Utah Bar Association

ADVANCE DIRECTIVES – SELF MANAGEMENT PLAN

What are Advance Directives?

To a certain extent, mental health consumers are able to assist mental health care professionals in managing many aspects of the consumer's mental health care needs. By creating a Self-Management Plan for Mental Health Care with the assistance of the consumer's support team. The consumer can identify strategies that have proven helpful in managing the consumer's mental health care, as well as strategies that have not. Also, by creating that plan while the consumer is competent to make informed decisions, the consumer has a way to communicate the consumer's preferences on a variety of mental health care issues to mental health professionals during times of consumer crisis.

Why Should I Know About Advance Directives?

By completing each part of the self-management plan packet, the consumer is able to express what the consumer's decision would be if, in the future, certain mental health care decisions need to be made and the consumer is unable at that time to make them.

Once the self-management plan is completed and signed, the consumer should keep a copy, as should each member of the consumer's support team.

To activate the plan, the consumer should deliver the original, signed copy to the consumer's support team. To activate the plan, the consumer should deliver the original, signed copy to the consumer's primary mental health care provider for inclusion in the consumer's file. The consumer should also consider delivering a signed copy of the consumer's self-management plan to the State Hospital for placement on the statewide computer network.

When Should I Begin the Process?

The process of creating a self-management plan should involve a series of discussions between a mental health consumer and that consumer's designated support team at any time when there is stability in treatment and the consumer is able to make choices about the future.

Where Does the Team Meet?

The consumer and his/her designated support team should meet at a convenient and "safe" place. The forms for creating a self-management plan are included with this curriculum.

Who Needs to Have Advance Directives?

A Self-Management Plan for Mental Health Care is for the consumer so that he/she can identify strategies that have proven helpful in managing the consumer's mental health care. As well as strategies that have not.

How Do I Get Started?

The process of creating a self-management plan should involve a series of discussions between a mental health consumer and that consumer's designated support team. The consumer's support team should be made up of people that the consumer wants to assist them in their efforts to manage their mental health care, and may consist of family supports (such as a spouse, children, parents, and siblings), community supports (such as friends, religious leaders, and employers), and professional supports (such as a case manager, physician, psychiatrist, counselor, therapist, and social worker). Discussions should focus on determining the consumer's thoughts about mental health care planning and the consumer's preferences about specific future mental health care decisions. The following forms provide a

framework for the decisions that should be discussed and can be used to record and communicate decisions that the consumer makes.

R E S O U R C E S

State of Utah Self-Management Plan for Mental Health Care forms

Declaration for Mental Health Treatment (Advance Directive)

1. A patient who does not meet the definition of "Incapable" may execute a Declaration for Mental Health Treatment.

   "Incapable" means that, in the opinion of the court in a guardianship proceeding under Title 75, Utah Uniform Probate Code, or in the opinion of two physicians, a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions.

2. They appoint an Attorney-In-Fact.

   "Attorney-in-fact" means an adult properly appointed under the law to make mental health treatment decisions for a declarant under the declaration for mental health treatment, (not liable for costs, can receive and review medical records, if declarant's wishes are unknown they act in the best interest of the declarant.)

3. The Declaration needs two capable adult witnesses. The witnesses shall attest that the declarant is known to them, signed the declaration

in their presence, appears to be of sound mind and is not under duress, fraud, or undue influence.

4. Witnesses or Attorney-In-Fact cannot be attending physicians or mental health providers, employees of the DSAMH or Local Mental Health Authority or its' contractor.

5. The Attorney-In-Fact may consent to Mental Health Treatment consistent with the Declaration. Mental Health Treatment means convulsive treatment, treatment with psychoactive medication, or admission to and retention in a facility for a period not to exceed 17 days.

6. The Declaration becomes part of the medical record. It becomes operative when delivered to the declarant's physician or other mental health treatment provider and remains valid until it expires or is revoked by the declarant. The physician or provider is authorized to act in accordance with an operative declaration when the declarant has been found to be incapable. The physician or provider shall continue to obtain the declarant's informed consent to all mental health treatment decisions if the declarant is capable of providing informed consent or refusal.

7. A physician or provider may subject a declarant to intrusive treatment in a manner contrary to the declarant's wishes, as expressed in a declaration for mental health treatment if:

   a. the declarant has been committed to the custody of a local mental health authority. The Declaration does not limit authority to civilly commit the declarant, OR
   b. in cases of emergency endangering life or health.

R E S O U R C E S

62a-15-1004. Declaration for mental health treatment – Form

Advance Directives – Planning for Psychiatric Treatment, by Ted Johnson, Office of Behavioral Health Services, Charleston, West Virginia.

HIPAA
The Health Insurance Portability and Accountability Act of 1996

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important new—but limited—protections for millions of working Americans and their families around the ability to obtain and keep health coverage. Among its specific protections, HIPAA does the following:

- Limits the use of pre-existing condition exclusions.
- Prohibits group health plans from discriminating by denying you coverage or charging you extra for coverage based on your or your family member's past or present poor health.
- Guarantees certain small employers and certain individuals who lose job-related coverage the right to purchase health insurance.
- Guarantees, in most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy.

In short, HIPAA may lower the individual's chance of losing existing coverage, ease the ability to switch health

plans, and/or help to buy coverage if an individual loses an employer's plan and has no other coverage available.

What is the HIPAA Privacy Rule?

The U.S. Department of Health and Human Services (DHHS) issued the privacy rule to implement the requirement of HIPAA. The privacy rule standards address the use and disclosure of individuals' health information, or "protected health information," by organizations subject to the privacy rule, or "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within DHHS, the Office for Civil Rights (OCR) has the responsibility for implementing and enforcing the privacy Rule with respect to voluntary compliance activities and civil money penalties.

What does the HIPAA Privacy Rule require providers to do?

Under the final privacy rules, covered entities must protect individually identifiable health information against deliberate or inadvertent misuse or disclosure. Consequently, health plans and providers must maintain administrative and physical safeguards to protect the confidentiality of health information as well as protect against unauthorized access. These entities must inform individuals about how their health information is used and disclosed and ensure them access to their information. Written authorization from patients for the use and disclosure of health information for most purposes is also required with the exception of health care treatment, payment, and operations (and for certain national priority purposes).

Why is HIPAA important?

A major goal of the privacy rule is to ensure that individuals' health information is properly protected while allowing the flow of health information needed to provide

and promote high-quality health care and to protect the public's health and well being. The rule strikes a balance that permits important uses of information while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

When does HIPAA apply?

- HIPAA applies to health care records which includes Mental Health
- HIPAA regulates the use (within the entity) and disclosure (outside the entity) of protected health information (PHI).
- PHI is 1) past, present, or future health information, 2) Individual identifiable, 3) Created or received by the entity, 4) In any form (oral, written or electronic).

WHERE
Who must comply with HIPAA?

As required by Congress in HIPAA, the Privacy Rule covers the items listed below:

- Health plans
- Health care clearinghouses
- Health care providers who conduct certain financial and administrative transitions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

How am I covered under HIPAA?

Every consumer is automatically covered under HIPAA. The following is true for the next of kin/care giver:

- Disclosure of PHI directly relevant to a person's involvement with the individual's care or payment of the individual's health care (This include disclosure to an individual's family member, relative, close personal friend, or other person identified by the individual.)
- Use or disclosure of PHI to notify a family member, personal representative, or another person responsible for the individual's care of the individual's location, general condition, or death.

Next of Kin/Care Giver Limitations

- Only allowed if individual, in advance, is given an opportunity to agree to or prohibit such disclosure (these communications can be oral) or if the entity reasonably infers from the circumstance, based on the exercise of professional judgment, that the individual does not object.
- The individual has a "Right to Request Restrictions" on the entity's use or disclosure of PHI otherwise permitted by the Next of Kin/Care Giver Exception. The entity is not required to agree, but if agreement is made, the entity must document the agreement and abide by its terms.
- If the individual is not present, or the opportunity to agree or object can not practicably be provided, an entity should use its best professional judgment and experience with common practice in deciding whether the disclosure under this exception is appropriate under the circumstances. Example: Pick-up filled prescriptions, medical supplies, or X-rays.

ESTATE PLANNING

Sample Family Estate Planning Documents

Dear Family:

Your Estate Plan requires two (2) trusts due to the special needs of your family. Your first Discretionary Trust which provides for the supplemental support of your family member with special needs. Your second trust is a Family Trust which provides for all of your other heirs. The benefits of each of these trusts are described below.

Discretionary Trust

Your Discretionary Trust is an irrevocable, inter-vivos trust that you cannot modify throughout your life. It confirms to the 1996 Utah law which exempts the assets of this trust from the estate of your family member with special needs in determining eligibility for government benefits. It protects your family member with special needs in at least four (4) ways:

(a) Your Discretionary Trust provides for the supplemental care, maintenance, support and education in addition to and over and above the benefits your family member may otherwise receive as a result of his or her handicap or disability from any local, state, or federal government or from any other private or public agency.

(b) Your Discretionary Trust provides a written documented plan for the supplemental support of the individual with special needs.

(c) Your Discretionary Trust avoids a conservatorship for the individual with special needs and saves time and money.

(d) Your Discretionary Trust protects the assets in the trust from creditors of the individual with special needs and government agencies

providing basic services to the individual with special needs.

It also has the drawback that any trust assets will first be available to the State upon the death of your family member with special needs up to and including the total medical assistance received by that individual from the government through the State of Utah and otherwise.

Family Trust

Your Family Trust is legally known as a revocable, inter-vivos, grantor-type trust. It protects you in at least five ways:

(a) Your Family Trust provides continuous, controlled management in the conservation and transfer of your estate.
(b) Your Family Trust provides a written, documented plan for proper distribution of assets to your heirs, including a family member with special needs.
(c) Your Trust avoids conservatorship and saves time and money should either of you become disabled.
(d) Your Family Trust avoids probate and saves time and money in transferring assets to your heirs at death.
(e) Your Family Trust maximizes your family's privacy.

Your Trusts work best only if approximately $100.00 is initially transferred to the Discretionary Trust and all of your other titled assets are transferred to your Family Trust.

For more information look up Estate Planning in the handouts for this section.

ACTIVITY:

Priority Cards:

1. Set out all cards in rows in front of you.
2, Choose your top 10 priorities for your youth with disabilities and take away the rest of the cards.
3. Study your 10 choices and choose your 5 highest priorities. Take away the other 5.
4. Study your 5 choices and choose 3 highest priorities. Take away the other 2.
5. Study your 3 choices and put them in order.

Remember that we can not solve all the problems, even though there are many that need our attention. Let's start at the point that is you have chosen as your highest priority.

HIPAA Privacy Protections

General Rule = Prohibiting Use and Disclosure of PHI

Required Exceptions

1) When an individual requests access to PHI about themselves.
2) When compelled by the HHS for compliance and enforcement purposes.

Permitted Exceptions

Written Authorization

1) Certain Psychotherapy Notes
2) Marketing
3) Authorizing Uses or Disclosures not Otherwise Permitted

Without Authorization

1) To the Individual
2) TPO
3) Incidental use/disc.
4) Facility Directory
5) Next of Kin/Care Giver
6) Business Associate
7) Averting a Serious Health/Safety Threat
8) Health Oversight
9) Judicial & Admin Proc.
10) Law Enforcement
11) Public Health Activ.
12) Required by Law
13) Research
14) Victims of Abuse
15) About Decedents

ESTATE PLANNING

I

GENERAL

As you acquire new assets (such as real estate, stocks, bonds, mutual funds, certificates of deposit) you should take title to them in your name as Trustee by using the following language ("U/A/D" means "Under Agreement Dated"):

Name, Trustee (and to her
Successors in trust) of **The –name-**
Family Trust, U/A/D month/date/year

Any asset titled in this manner will be considered owned by you, as Trustee; the asset will be subject to your control and to the terms of the Trust Agreement.

If you so desire, assets may be held by your Discretionary Trust, even though we don't recommend this if you wish to maintain the integrity of your estate plan as outlined herein. Contributions to the Discretionary Trust are provided for through your Family Trust on a planned basis. However, if you wish to transfer particular assets to the Discretionary Trust outside the Family Trust you should take title to them in the name of the Trustee by using the following language ("U/A/D" means "Under Agreement Dated"):

DISCRETIONARY TRUST
NAME, Trustee (and to her successors in Trust) of THE –NAME- DISCRETIONARY TRUST, U/A/D month/date/year

II

IRA'S AND OTHER QUALIFIED RETIREMENT PLANS

Contact the custodian or administrator of your IRA's, profit sharing plans, TIAA/CREF, 401(k)'s or other qualified retirement plans. Ask for the

proper forms to designate your beneficiaries. Your beneficiary designations should be as follows:

(a) Your spouse should be the **primary beneficiary**, unless it is your desire that he/she should not receive such plan assets at your death, or unless he predeceases you, in which case the Trust should be listed as Primary Beneficiary. If you do list your spouse as primary beneficiary, then your Trust (using the same language suggested below for insurance) should be the **secondary beneficiary**.

III

LIFE INSURANCE DEATH BENEFITS

Contact your insurance company and ask for a "beneficiary designation form" for each policy. You should name the Trust as the primary beneficiary, as follows:

NAME, Trustee (and to her successors in Trust) of THE –NAME- DISCRETIONARY TRUST, U/A/D month/date/year

IV

STOCKS, BONDS, AND OTHER INVESTMENTS

All stocks, bonds, brokerage accounts, and other securities, including investments and partnership interests, should be titled as shown above. You may be required, in the case of stock certificates, to surrender them, temporarily, to your broker, who will then assist you in having them reissued in the name of the appropriate Trust. If you have a brokerage account, changing the title of the account to the Trust will cause all future security acquisitions within that account to be titled automatically in the name of the Trust. Most brokerage houses will require a copy of your Trust Agreement in various types of stock and investment transactions. You should comply with their request. Generally, you should write to whomever you have

business dealings with for specific directions. Your attorney should be glad to assist in this process.

V

BANKS, SAVING & LOANS, CREDIT UNIONS, ETC.

You should contact your savings institutions and ask them to change the signature card of your accounts to show ownership of your accounts in the name of the Trustee of the appropriate Trust. Usually your checks and checking account numbers will not need to be reprinted or changed. You will probably have to sign a new signature card that shows the Trust as the new account owner. Again, you may be asked to furnish the institution with a copy of your Trust Agreement.

VI

VEHICLES

Motor vehicles are generally not appropriate trust property, because they represent rolling liabilities as much as assets. In the event of an accident involving a trust automobile, disclosure that the owner is a trust is an invitation to file a lawsuit.

VII

INTERESTS IN REAL ESTATE

All interests in real estate, such as land, buildings mortgages, and trust deeds to contracts, should be deeded or assigned to the Trust. Your attorney should provide a deed for your personal residence. For other real property interests, however, please contact your attorney regarding the tax and legal complexities and for assistance in preparing any necessary documents to effect the transfers.

ESTATE PLANNING DOCUMENTS

I

PROCEDURES AT DEATH

This form gives step-by-step instructions as to what should be done at your deaths. In addition, funeral, burial or other instructions as you see fit may be added to this form.

II

DISCRETIONARY TRUST

You or your named designee are the Trustee for this trust during your life. After you pass away, your named successor trustee(s) will have full control of all trust properties without probate. The primary beneficiary is your family member with special needs. The Successor Trustee(s) has been instructed in the Trust Agreement to provide for the supplemental needs of the primary beneficiary. At the death of the primary beneficiary the State of Utah will receive the assets of the Trust up to and including the medical assistance received by the primary beneficiary which will most likely be all the assets of the trust. After this distribution the balance of the Trust assets will be transferred to the Family Trust for distribution thereunder.

III

FAMILY TRUST

You are both the Trustee and Beneficiary. You control all aspects of the Trust, including investments and distributions for your benefit. After you pass away, your named successor trustee(s) will have full control of all trust properties without probate. They will distribute your assets according to your specific instructions which include the transfer of assets to the Discretionary Trust as funds are needed therein.

IV

POUR-OVER WILLS

The Will simply "pours" all assets "over" to the trustee(s) of your Family Trust. The Will also appoints personal representatives for your estate and a guardian for your minor children and your adult incompetent children.

V

MEMORANDUM OF TANGIBLE PERSONAL PROPERTY

The Utah Probate Code expressly permits the use of a written statement that is separate from your will to dispose of your tangible personal property upon your death.

VI

DURABLE POWERS OF ATTORNEY

With these documents, you appoint an attorney-in-fact. If you become incapacitated or unavailable for any reason, your attorney-in-fact can still transact any business or handle any matter. The first Power of Attorney is specifically to allow your attorney-in-fact to transfer assets into your Family Trust. If you require a Power of Attorney for any other purposes, your attorney will be happy to discuss your needs with you at any time.

VII

SPECIAL POWER OF ATTORNEY FOR MEDICAL PURPOSES

A person 18 years of age or older, the "principal," may designate any other person 18 years of age or older to execute a directive under UCA Section75-2-1105 on behalf of the principal after the principal incurs an injury, disease, or illness which renders him unable to make a directive, by executing a special power of attorney before a notary public. A directive executed by an attorney-in-fact appointed under this special power of attorney for medical purposes takes precedence over all previously signed directives.

VIII

LIVING WILLS

"Living Wills" or Directives to Physicians express your right to a natural death in the event of a terminal illness or injury.

Directive to Physicians and Providers of Medical Services. The directive you execute is in accordance with the Utah Personal Choice and Living Will Act. This Act provides you with the means of dictating now what medical treatment you will receive in the event you have a terminal condition and you don't have the capacity to make a decision at that time.

By executing the directive, you will specify that life sustaining procedures should be removed in the case of a disease, injury or illness where two physicians certify that, in their reasonable medical judgment, life sustaining procedures would only postpone the moment of your death. You will dictate that you be permitted to die naturally.

IX

LETTERS OF TRANSFER

Your trust will not provide any benefit for you unless your assets are transferred into the trust. We assist you in this regard by preparing the necessary documents (Deeds, Bank Letters, Investment Letters, etc.) at the time your trust is established for the assets that you disclose to us.

OTHER MATTERS

I

INCOME TAXES

Setting up your Family Trust should not change your method of reporting personal income taxes. Because your Family Trust is revocable, you must report all of the Trusts' income as your own personal income on your personal tax return (form 1040) and not on a separate tax return for this

Trust. Your Social Security number can be given to anyone who asks for a tax identification number for your Family Trust, for purposes of reporting its income. This number will probably be requested by the bank at which you open accounts and by the broker when you transfer securities into the name of your Family Trust.

Setting up your Discretionary Trust will change your method of reporting income taxes. Because your Discretionary Trust is irrevocable, you must report all of that Trust's income on a form 1041 fiduciary return as a separate tax return for the trust. The Discretionary Trust will need to receive its own tax identification number to report its own income and pay the tax due on its own income. This number will probably be requested by the bank at which you open accounts and by the broker when you transfer securities into the name of the Discretionary Trust.

III

REGULAR ESTATE PLANNING REVIEWS

Your estate plan will be only as effective as your maintenance program. You should spend a few hours each year carefully reviewing your plan to verify that it still accomplishes your goals. You should explain the basic elements of the plan to your family. If you wish to change your plan, you should contact us, and we will provide you with minor changes for a minimal fee, and for major changes, a fee based upon the anticipated work to be performed will be discussed and agreed upon prior to such work commencing. If any of the following circumstances apply to you, you should contact us for a review: (a) any major change in your net worth (assets appreciate, you receive an inheritance, etc.); (b) death, marriage or divorce occurs in your family; (c) you desire changes in your trust or the provisions of your will; or (d) you acquire new assets with titles (bank accounts, vehicles, investment, real estate, etc.), which are not in a Trust.

Section 5:
DREAMING NEW DREAMS
LOOSENING UP

Nancy's story…
I vaguely recall some proverb that says if you give a man a meal, you have fed him for a day, but if you teach a man to fish, you have fed him for his life. I would like to use this analogy as I share an example of how to teach our seriously emotionally disturbed youth, so that they can feed themselves for life.

The goal of most caregivers is to help our youth be as independent as possible, yet how we teach our children is the key to our being able to let go, and them being able to have that independence.

Recently, my child needed to ride the bus from Clearfield to Salt Lake City by herself. The location in Salt Lake City required at least one bus transfer. This was a challenging undertaking and we did some role playing on how/when to ask for directions. We also talked about not getting frustrated if they got on the bus going the wrong direction.

One caregiver that my child had wrote out directions on which bus to catch and left these for my child to follow. These directions would have gotten my child to their destination, but not on the closest or most direct route. More importantly, these directions were specific to that task.

My child was rather unsure still, and asked another caregiver for helping knowing how to navigate this task, and reassurance that they had the directions down correctly. The second caregiver took my child, and showed her where/how to call UTA and receive directions from any destination from any destination to any destination, and how to ask the bus driver for help in identifying the correct stop.

Both sets of directions would have resulted in my child reaching the destination, but the second set of directions, resulted in my child now having a life skill that can be used for the next adventure. My child successfully completed the task of getting from Clearfield to Salt Lake City and felt a sense of accomplishment as well as a sense of empowerment at having learned how to do a similar task again.

As we teach our youth to be independent, we must keep in mind those teaching moments that with a little extra effort, we can teach a life skill that will help them reach that goal.

"Nothing will ever be attempted if all possible objections must first be overcome."

-Samuel Johnson

What Is Loosening Up?

"We don't have a clue as to what people's limits are. All the tests, stopwatches, and finish lines in the world can't measure human potential. When someone is pursuing their dream, they'll go beyond what seems to be their limitations. The potential that exists within us is limitless and largely untapped." - Robert J. Kriegel

Why Is Loosening Up Necessary?

Adolescence is a time of independence, a time when young adults begin to take more responsibility for meeting their own needs. Many young adults with disabilities begin to "strike out on their own" and seek less interference and involvement from their parents. **Greater independence means higher risk**. Risk taking is an essential component of adolescence and an important component of gaining independence.

When Is Loosening Up Appropriate?

When young adults with disabilities move from the school system into the community, their parents experience the same feelings that all parents do when it is time to "loosen up" and allow their kids to try things on their own. Letting sons and daughters with disabilities "try their own wings" can be more frightening because they have usually been more dependent on others.

Some parents are afraid their sons and daughters can't make it without them. Others fear transition because change involves risk and they're afraid their young adult may fail in some new task, be injured, or treated poorly.

No parent wants to expose a young person to risk, especially one who has a higher than average chance of failing. Yet most parents know that risk-taking is essential for the long-term development of social and personal competence.

It is easier for parents to learn to "let go" when they understand what "holding on" looks like.

ACTIVITY:
(Show Garth Brooks video "Standing Outside the Fire")

What are some examples of "holding on" to our kids too tight?
(Possible answers: always watching or calling to check on the individual, treating kids as if they were younger than their chronological age, doing things for young adults that they can do themselves, being either too controlling or too permissive.)

Who Is This For?

Parent's fears about physical or emotional harm are real, but protecting young people from reasonable risks robs them of an opportunity to become as independent as possible as they transition to adulthood. **The passage from childhood to adulthood for all of us involves the "dignity of risk"; the right to make mistakes and learn from them.**

The negative consequences of shielding young adults from taking risks can be more damaging than the consequences of an occasional mistake or failure.

To prepare for their independence, adolescents should be given opportunities to practice prior to adolescence. A child may want to spend 2 weeks away at camp, which might terrify parents. Allowing the child to spend weekends camping with friends or spending a few nights away from home visiting a relative could gradually increase confidence in her or his independence.

How To Get There…

Breaking a desired goal into **smaller steps** helps build confidence and supports families as they enter this tough transition to independence.

Have any of you had success that was a result of allowing your son or daughter to "take risks"?

While young adults are preparing to transition into the community, parents' needs for support and information may be as great or greater than they were when their child's disability was first diagnosed. The support of other parents who are facing the same decisions and risks can be very valuable.

It may be time to reactivate old support groups or form new ones. Together with other parents it is easier to find out about adult services, guardianship, SSI, wills and trusts. Most of all, parents need to share their feelings with people who understand their hopes and fears.

Let's not get lost, let's help each other! Raising these kids can be tough.

"What you can do is often simply a matter of what you will do."
"That's why," said Azaz, "There was one very important thing about your quest that we couldn't discuss until you returned."
"I remember," said Milo eagerly. "Tell me now."
"It was impossible," said the king, looking at the Mathemagician.

"Completely impossible," said the Mathemagician, looking at the king.
"Do you mean---"stammered the bug, who suddenly looked a bit faint.
"Yes, indeed," they repeated together; "but if we'd told you then, you might not have gone – and, as you've discovered, **so many things are possible just as long as you don't know they're impossible."**

SOMETIMES THIS IS WHAT WE NEED TO REMEMBER – TAKE COURAGE!

Although it is especially difficult for you to allow and encourage your daughter with disabilities to strike out on her own, it is easier when preparations have been made in advance. You will be less traumatized if you view "loosening up" as a process and use transition planning to provide an approach that lays adequate groundwork for successful independence.

As she moves toward adulthood and independence, you can encourage her to make choices and discipline yourself not to interfere. Even if you are afraid she may fail at some new task or be treated poorly by others, you must recognize that risk-taking is essential for her personal growth, ultimate well-being, and long-term happiness.

"You may be disappointed if you fail, but you are doomed if you don't try."

- Beverly Sills

THE NEED FOR SUPPORT GROUPS

A diagnosis of a serious emotional disturbance in a child may produce a parental sense of loss – loss of a dream of a good life for the child, loss of the sense of the child as healthy and whole, loss of the sense of competence to protect the child, loss of the sense of control over life, loss of the future as dreamed.

A diagnosis of a serious emotional disturbance in a child may produce **normal** feelings of guilt, anger, fear, isolation, and frustration. These feelings may be strange and frightening for parents and families.

The stresses which the child's mental health condition creates for the family are:

Intellectual – to master massive amounts of new and complex information;

Practical – to find solutions to the day-to-day problems of arranging personal and family life around the child's condition and treatment;

Interpersonal – to create new relationships and adapt as old ones are disrupted;

Emotional – to respond to a threat to a child's future and a family's living pattern.

Families face many challenges:

To help the child cope with the disability and its treatment while meeting the everyday pressures of growing up.

To protect and promote the emotional well-being of both individual family members and the family as a whole;

To preserve normal relations with the family member's wider community of extended family, neighborhood, friends, school, workplace.

To build mutually trusting and cooperative relationships with the mental health care team.

These challenges also present parents with an opportunity – an opportunity to respond with solutions, assistance, and interventions which will meet the needs of their child and family, the needs of other parents/families, and the needs of the professional community serving their families. One of the most effective responses in providing support and developing coping skills has been the creation of parent support groups.

THE NEED FOR PREVENTION PLANNING WITH TRANSITION-AGED YOUNG PEOPLE

1. What is Prevention Planning?

- A prevention plan is a collaboratively determined set of responses to an impending or potential high-risk situation.

2. Why Do Prevention Planning?

- To identify specific behaviors and clarify consequences.
- To interrupt patterns of on-going high-risk activity.
- To help people identify desired support and interventions.
- To enhance self-empowerment and coping skills.
- To provide documentation of decisions and agreements.
- To strengthen individual and team accountability.
- To increase the effectiveness and coordination of a team's response.
- To increase the likelihood that a situation will be handled in a manner most satisfactory to all.

3. Who Should Be Involved?

- Young person
- Transition facilitator or service coordinator
- Desired and/or identifiable support persons
- Members of the transition planning team

4. When to Do Prevention Planning?

- When there seems to be anxiety or concern on the part of the young person or other key players.
- When individual is choosing to engage in high risk activities.
- When there is an impending high-risk situation.
- When there is an ongoing pattern of high-risk behaviors.
- When a plan will enhance individual self-monitoring and self-management.

5. What Does a Prevention Plan Look Like?

- Many different approaches – formal and informal.
- Plans include the following basic information:
    - State the purpose of the prevention plan
    - Describe the situation, including critical or target behaviors, typical precursor, and/or personal triggers
    - Self-management coping strategies
    - External supports and clear specification of roles
    - Interventions/action plan, including teaching of skills
    - Conditions for hospitalization/incarceration/crisis placement
    - Agreement among young person and all key players.

H.B. Clark adapted (2001) from Michael Curtis and Phil Wells

R E S O U R C E S

Local parent support groups:

Davis County Parent Support Group (RESPECT) – Meets the 3rd Thursday of each month. Call Allies with Families at 1-877-477-0764 or (801) 292-2515.

Utah County Parent Support Group meets the 2nd Wednesday of each month. Contact Glen Sexton at (801)678-1746 for more information.

Emery County Support Group (Families Connected) – Call Four Corners Community Mental Health at (435) 637-1497 for more information.

Carbon County Support Group (ROAR) - Call Four Corners Community Mental Health at (435) 637-1497 for more information.

Green River Support Group (Family Forum) – Contact Denise Hoffman at (435)820-1122.

Grand County – Moab (Helping Hearts) – Contact Yvette Clark at (435) 259-2930.

Grandfamilies (Relatives as Parents Support Services) Support Group – Meetings are held once a month for grandparents and other relatives who are raising their kin's children. Children also have activities during the support group meeting. Call (801) 355-7444 for more information

Beaver County Family Support Group – Call Wendy Yardley (435) 438-5364 for more information.

Kanab County Family Support Group – Call Tracy Johnson, New Frontiers for Families, (435) 676-2599 for more information.

Garfield County Family Support Group - Call Tracy Johnson, New Frontiers for Families, (435) 676-2599 for more information.

Allies with Families
450 E. 1000 No. #311
North Salt Lake, Utah 84054
(801) 292-2515
Toll Free 1-877-477-0764
FAX: (801) 292-2680
www.allieswithfamilies.org

NAMI – Utah
309 E. 100 So.
Salt Lake City, Utah 84111
(801) 323-9900
Toll Free 1-877-230-6264
www.namiut.org
call for local affiliate group times and dates of meetings

Project RECONNECT
Jane Lewis, Project Director
Division of Substance Abuse and Mental Health
240 West 200 North, 2nd Floor
Salt Lake City, Utah 84103
(801) 538-3912

Family Advisory Council – Allies with Families (see above)

Bibliography for Dreaming New Dreams/Loosening up

1. The Need for Prevention Planning with Transition-Aged Young People - *H.B. Clark adapted (2001) from Michael Curtis and Phil Wells.*

2. Prevention Planning Process - *H.B. Clark adapted (2001) from Michael Curtis and Phil Wells.*

PREVENTION PLANNING PROCESS

1. Identify situation: problem behavior, setting events, risk factors, risk behavior patterns, situation anxiety, and possible secondary gains for the young person.

2. Explore the young person's feelings and personal triggers related to the high-risk situations.

3. Identify purpose and possible benefits of a prevention plan to the young person.

4. Identify others who should be involved in developing the plan. Secure their perspectives regarding Steps 1, 2, and 3.

5. Convene meeting with identified transition planning team. Orient team to 1, 2, 3, and 4 above. Solicit additional input from young person and other team members.

6. Identify what skills the young person needs to cope with triggers and stressors prior to the high-risk situation. Specify specific coping strategies.

7. Explore what the young person needs to feel safe in a high-risk situation.

8. Clarify key support persons for individual to contact when needed.

9. Develop a prevention action plan:

    - Include as many proactive and preventative strategies as possible.
    - Build on the young person's strengths and natural support network to the extent possible.
    - Examine strategies to minimize possible secondary gains for young person.
    - Teach skills to young person to provide replacement behaviors that enable the young person to acce3ss more appropriate social and non-social reinforcers.
    - Teach coping skills.

        - Recognition of one's trigger stimuli (internal or external)
        - Teach alternative responses
        - Stress management
        - Avoidance of high-risk situations
        - Self-imposed respite or escape responses

    - Remove means of doing self harm.
    - Increase support and/or teach increased utilization of necessary supports.
    - Identify conditions (legal, individualized needs) under which the following types of interventions would be utilized: emergency medical unit, police, hospitalization, medication review, detoxify or crisis unit, and/or involuntary commitment.

- Specify and interventions that <u>should not</u> occur: (e.g., removal from school/work/home, forced medication, involuntary commitment if alternatives available).
- Build plans that "triage" responses to differing level of crisis intensity and severity.

10. Clarify any conditions which would void the plan (e.g. legal).

11. Sign and date the plan. Make sure all participants, including young person, have a copy of the plan and are clear about their roles.

12. Review and update the plan on a regular basis or as needed.

13. Resume your strength and future focus with the young person.

H.B. Clark adapted (2001) from Michael Curtis and Phil Wells

THE PASSAGE FROM CHILDHOOD TO ADULTHOOD FOR ALL OF US INVOLVES THE "DIGNITY OF RISK" – THE RIGHT TO MAKE MISTAKES AND LEARN FROM THEM.

I see children as kites

You spend a lifetime trying to get them off the ground.

You run with them until you are both breathless.

They crash, they hit the rooftop.

You patch and you comfort.

You adjust and you teach.

You watch them lifted by the wind and assure them that someday they'll fly.

Finally they are airborne, and they need more string and you keep letting it out.

But with each twist of the ball of twine there is a sadness that goes with the joy.

The kite becomes more distant and you know that it won't be long before that string will snap and the lifeline that holds you together will no longer be the same.

A child, as a kite, must be prepared to soar, as they are meant to soar, free and alone, to the greatest extent possible.

And only then can we collectively say that we have done our job.

Anonymous


Those who say
it cannot
be done
should
not
interrupt
the person
doing
it.
CHINESE PROVERB

SECTION 6: DEVELOPMENTAL MILESTONES

WHAT ARE THE DEVELOPMENTAL MILESTONES?

Stages of adolescent development

Adolescence can be summed up on one word: change. Only infants grown and change as rapidly and extensively as do adolescents. Understanding adolescent development—how children mature between the ages of 9 and 21, how those changes affect their families and other people around them, and how the surrounding culture and society influences that development—is critical to planning and implementing programs that can give teens the tools and skills they need to make and carry out responsible decisions.

Although adolescence is often discussed as one phase, teens actually pass through three distinct stages on their path to adulthood—early, middle, and late adolescence. Specific physical, cognitive, and social and emotional developments mark each of these stages. The changes that occur and the timing of those changes differ for boys and girls and vary greatly among individuals. However, in general, early adolescence is from the ages of 9-13, middle adolescence is from 13-16, and late adolescence is 16 and older.

KEYS TO EARLY ADOLESCENCE

- **Significant physical/sexual maturation**
- **Concrete thinking**
- **Increasing influence of peers**
- **Growing independence in decision-making**
- **Transition from elementary to middle or junior high school.**

EARLY ADOLESCENCE

Physical changes and characteristics

Early adolescence is marked by significant physical changes. Girls develop breasts, grow underarm and public hair, and begin menstruating. Boys develop deeper voices, grow hair under the arms and around the genitals, and begin to show other physical signs of sexual maturity.

In response to these physical changes, young adolescents—girls in particular—begin to be treated in a new way by their families and by society. As their sexuality becomes more apparent, girls begin to feel differently about themselves and they engender new reactions from those around them. They may no longer be seen as just children, but as sexual beings to be protected—or targeted. Parents may become overprotective or begin to allow greater freedom. These changes are complicated by the fact that girls mature at different ages.

Boys tend to receive less information about the physical changes that accompany their transition to manhood than do girls about their maturation. For example, school classes and parents will explain menstruation, but often leave out mention of wet dreams, erections, and ejaculation when talking to boys out of fear that these topics are too sexual or controversial. Boys may start to face pressure to differentiate themselves from their mothers and from female behavior. In addition, boys often face ridicule from peers if they are slower to develop physically.

Whatever the response from the people around them, girls and boys are treated differently as they move into adolescence because they look grown up and society has specific social expectations for how young men and women should behave.

These pressures can be difficult for teens to deal with, especially without guidance and support from caring, competent adults.

To further complicate this transition, recent studies have found that for some girls, adolescence is starting earlier. While the average age of onset of menstruation is close to 12.5 years, a small but growing minority of girls, particularly African American girls, are actually beginning to menstruate as early as age 8 (Marano, 1997).

For these children, the shift in how they are treated by the people around them may be even more difficult to cope with. New data from the national Longitudinal Study on Adolescent Health has found that looking older than one actually is constitutes a risk factor for early intercourse, although it does not place one at higher risk of teen pregnancy (Blum and Rinehart, 1997).

Cognitive changes and characteristics

Most early adolescents still think predominantly in concrete terms. They relate information and experiences to what they currently know and have a hard time thinking about the future or about things they have never been exposed to. Their ability to think abstractly—to project into the future and to understand intangible concepts—develops as adolescence progresses.

The fact that most early adolescents cannot think abstractly has important implications for program planning and necessitates different program approaches than would be created for older adolescents. For example, pregnancy prevention programs that ask early adolescents to picture what future opportunities would be lost by becoming a teen parent will not be very effective with young people.

WHEN DO DEVELOPMENTAL CHANGES HAPPEN?

Social and emotional changes and characteristics

In the early teen years, the values that children have learned from their parents begin to be tested by peers. Peers start to exert a stronger influence, and young teens will begin to be preoccupied with how their peers dress and behave. Young adolescents will start to experiment with their identity, trying out different ways of acting and seeing how people around them react to these various strategies.

Young teens also begin to enjoy more freedom to make their own decisions and may receive less ongoing supervision. Because they have little experience with the consequences of

their actions, early adolescence can be a time when risks are taken unknowingly. These young teens may not appreciate the potential impact of their actions.

Young adolescents may also experience a transition within the school setting from elementary school to middle and junior high school. Middle and junior high school brings with it increased responsibility and independence for which some young people are not prepared. For some young teens, a difficult transition to middle school and an unsuccessful middle school experience increases the likelihood that they will drop out of school. This is associated with a higher risk of teen pregnancy. Young people experiencing difficulty in school merit special attention.

MIDDLE ADOLESCENCE

Physical and cognitive changes and characteristics

Middle adolescents are portrayed most frequently in the media and thought of by most adults as the "typical teenager." In this stage, the physical changes continue. Middle adolescents begin to develop the capacity to think abstractly, but it will be several years before those habits of thought are firmly established.

KEYS TO MIDDLE ADOLESCENCE

- **Continuing physical/sexual changes**
- **Intense focus on body image**
- **Beginning of capacity to think abstractly**
- **Enormous influence of peers/school environment**
- **Risk-taking**

One day a middle teen is able to think long-term and project his or her thinking far into the future. The next day, he or she is back at a very concrete level, focused on the here and now, the day to day.

Social and emotional changes and characteristics

Teen girls, in particular, become extremely susceptible to the cultural messages they receive about appropriate body size and grooming. One observer of contemporary teen women comments: "In the twentieth century, the body has become the central personal project of American girls" (Brumberg, 1997). While a large percentage of American girls report dieting behavior as early as the 4th grade, middle adolescents

sometimes develop eating disorders and other body image disturbances. Increasingly, boys in our society are also receiving pressure to look a certain way and some boys are also experiencing eating disorders and other body image problems.

HOW TO GET IT – MORE HELPFUL HINTS

TIPS FOR WORKING EFFECTIVELY WITH TEENS

- **Ensure that program staff are trained in adolescent development,** are comfortable with adolescents, and refrain from stereotyping teens.
- **Allow teens to develop outreach and marketing materials for programs.** This will ensure that posters, flyers, and advertisements are in teen-friendly language and are culturally appropriate.
- **Appreciate the pressures and issues faced by today's teens.** Provide opportunities to discuss these broad struggles and not just the single issue on which a program focuses.
- **Be sure program hours are convenient** and that appropriate stipends, food, transportation money, or incentives are offered for participation.
- **Assure confidentiality to teens,** and let them know up front if something cannot stay confidential. Teens are more likely to open up to adults when they trust that what they say or do will remain confidential.
- **Coordinate efforts with other youth-serving providers** to try to eliminate duplication of services and to give young people the comprehensive information, skills, and opportunities they need to successfully negotiate adolescence.

Teens' focus on physical attractiveness is heightened by the huge effect of peers on one another during this stage of development. Parents and their beliefs now may be secondary to the norms and pressures—both positive and negative—of a teenager's peer group. Research has found that groups of friends have a greater influence than a best friend and that teens who choose positive peer groups fare much better than those who choose groups that may influence them to engage in negative behaviors.

Parents can also have an effect on how teens deal with friendships. An effective parenting style in helping to moderate peers' influence is an "authoritative parenting style" that combines control and warmth (McIntosh, 1996) –that is, parents who maintain a close, warm relationship with their teen and who set and monitor reasonable limits for his or her behavior.

For many teens at this stage of development, school can become a less hospitable place. More than 80 percent of public school students in grades 8-11 say that they have been the recipient of unwelcome sexual comments or advances, usually from another student (Blum and Rinehart, 1997). More than 12 percent of students report that they have carried a weapon to school in the past month (Blum and Rinehart, 1997).

This is particularly problematic because "school connectedness"—a student's school attendance and perceptions that she or he gets along with and is close to teachers and students, and feels that other students are not prejudiced—can protect against many harmful behaviors, such as too early intercourse, emotional distress, suicidal thoughts and attempts, violence, cigarette use, alcohol use, and marijuana use (Blum and Rinehart, 1997). Young people who are being harassed or fear violence in school settings are less likely to remain connected and feel positive about that setting and are at risk for dropping out. This, in turn, puts young people at higher risk of early and unprotected sex.

Risk-taking is often associated with middle adolescence. Adults who work with youth must keep in mind that risk-taking behavior has positive as well as negative aspects. Adolescence is an appropriate time for trying new things and taking new risks. However, adolescents have often been portrayed as taking extreme, ill-considered risks. In fact, research shows that adolescents are about as good at assessing the actual risks of a situation or action as are there parents. This recent work

suggests that helping parents to be better judges of risk will also help young people.

LATE ADOLESCENCE

Physical, social, emotional, and cognitive changes and characteristics

Late adolescence is often thought of as early adulthood in our culture. Teens in this stage are beginning to take on adult roles and responsibilities and may be living independently from their families. The physical changes of adolescence are complete. At this stage, family influence comes into balance with messages from peers. Most older adolescents have developed a sense of identity and a sense of both their similarities and their differences from parents. Late adolescents are firmly rooted in abstract thinking. They are thinking about the future and functioning, cognitively, as adults.

KEYS TO LATE ADOLESCENCE

- **Physical/sexual changes complete**
- **Capacity for abstract thought in place**
- **Adult cognitive functioning**
- **Family influence in balance with peer influences**
- **Transition to work, college, independent living.**

WHY SHOULD WE KNOW ABOUT THE DEVELOPMENTAL MILESTONES

It takes our youth longer to achieve success, in most cases. We must start earlier and plan ahead if our youth are to face adulthood prepared.

WORKING IT OUT: LEARNING TO NEGOTIATE WITH YOUR TEENAGER

Checkpoints for Successful Negotiation

- ✓ Communicate clearly
- ✓ Respect the other person
- ✓ Recognize and clearly define the problem
- ✓ Seek solutions from a variety of sources
- ✓ Collaborate to reach a mutual solution
- ✓ Be reliable
- ✓ Preserve the relationship

Negotiation is a Process

Negotiation is one of several ways to resolve conflict. It can be used when parent and teenager have taken a position on an issue. Negotiation is the process by which conflict can be resolved so that both parent and teenager feel like they have achieved a solution.

Problem-solving negotiation is:

- Listening and understanding
- Having concern for the relationship
- Satisfying the interests of both sides
- Inventing new options
- Reaching an agreement based on fairness.

Common areas for negotiation with teenagers are:

- Money
- Grades
- Transportation
- Recreation
- Convenience
- Clothing
- Chores
- Social manners

Topics included in negotiation are chosen based on a child's skill level and maturity level. The frequency of negotiation increases as a child grows older. During late adolescence almost all

rules may be negotiated, with the parent maintain a few rules that won't be negotiated. The teen is trying to break the walls to independence and may push against some of these rules.

Communication is Key

The key to effective negotiation is clear communication. Communication involves three important skills: speaking, listening and understanding. Negotiation doesn't work using just one of these skills. For example, you can't have good understanding without good listening and speaking. Negotiation is most effective when both parent and teenager are able to clearly identify and discuss their sources of disagreement and misunderstanding.

When you assume that you know what someone is going to say before he says it, you increase the chances of misunderstanding what he really does say.

Effective negotiation is a two-way process that encourages both sides to participate in making decisions. It also provides a way for parent and teenager to learn to understand each other better and to grow in their relationship. Negotiation helps create a healthy balance between giving and getting. Everyone becomes a winner through negotiation.

Rethink the Conflict

Rethink is one good way to remember how to approach conflict and to begin negotiating.

R -- **Recognize** when you're angry. Learn to help yourself relax.

Rethink it:

What are my body's anger signals? Do I experience increased heart rate, muscle tension, upset stomach, and headache? What other feelings am I having that my anger may be hiding? Do I feel hurt, stressed embarrassed, scared?

What can I do to help myself cool down?

- Step back and take a deep breath before reacting.
- Tell yourself things like, "It's OK. Take it easy. I can handle this."
- Count to 10.
- If necessary, take a break, walk away, listen to music, chill out in your own way, and THEN deal with things.

E -- **Explain** the situation from the other person's point of view; empathize.

Parent rethinks it:

What is my teenager thinking? Feeling?
When I was a teenager, did I ever feel that way?
If I was in my teenager's shoes, how would I react?
What else might be going on in his/her life that may be contributing to the problem?

Teen rethinks it:

What is my parent thinking? Feeling?
If I was a parent, how would I feel?
What would I do if I was a parent in this situation?
What else is happening in Mom's or Dad's life that makes this problem difficult?

T -- **Think** about how you may be contributing to the problem:

Rethink it:

Can I look at this situation in a different way? Can I find some humor in it?
What am I thinking about when I'm angry? Are my thoughts feeding my anger?
What else is happening in my life that might be contributing to the problem?
Is this a battle worth fighting, or should I let this one slide?

H -- **Hear**, really hear, what the other person is saying. Listen to the feelings as well as the words.

Rethink it:

How can I be sure I understand how the other person feels and show that I do?

- Give the person your full attention, lean forward, make eye contact and don't interrupt.
- Test how well you understand the other person's point of view by putting his/her ideas into your own words, asking questions as necessary.
- Listen for the emotions, not just the thoughts. Say, "I can tell you feel…"

I -- **Include "I"** statements. Use sentences that begin with "I feel… when…" to explain how you feel.

Rethink it:

How might stating my feelings help the situation?
How would a sentence that starts with "You…" make someone feel?

N -- **Negotiate** to try to work things out to everyone's satisfaction.

Rethink it:

Have I considered how I may have helped create the problem? What might I do to help fix things?
What can I reasonably ask of the other person to help the situation?
How can I figure out a solution or compromise?

Steps of negotiation:

- Explain your position as calmly and simply as possible.
- Listen, and be sure you understand the other person's point of view.
- Don't make demands, lecture or bring up old grudges.
- Suggest and discuss some options you can both live with.
- If all else fails, take a break or agree to disagree.

K-- Show **kindness** even when expressing anger. You can get something off your chest without trying to hurt the other person.

Rethink it:

Can I say something positive about the person or the situation with my negative feelings?
Is my tone of voice calm?
Am I avoiding sarcasm and put-downs?
Can I use a sense of humor to lighten a tense moment?
Am I keeping in mind any outside issues that may be affecting how we're both feeling?
Am I focusing my comments on the problem and not the person?

R E S O U R C E S

The Theory of Negotiation

Bibliography

Jacobson, DonnaRae, Family Science Specialist and Lesmeister, Marilyn, Leadership & Volunteer, *Working it Out: Learning to Negotiate with your Teenagers,* May, 1995

RECAP: INDEPENDENCE VS. INTERDEPENDENCE

ACTIVITY:

1 Ball of Yarn needed
Role labels for: youth, parent, educator, friend, foster parent, case worker, therapist, doctor, job coach, sibling, extended family members, etc.

Group should be in a circle. Start with the youth holding the ball of yarn.

1. Holding on to the end of the yarn, the youth passes the ball to the person who they think is most helpful to them.
2. Holding on to that section of yarn, that person then passes the ball to who they think is most important to the child
3. And so on, and so on.

At the end you should see a web-like structure that would show the importance of interdependence in this youth's life.

SKILLS ASSESSMENT for SUCCESS on the JOB & in the COMMUNITY

Category	Specific Skill	Needs Training	Needs Support	Does Now
Punctuality	Is ready for school on time			
	Shows up at expected time			
Dependability	Calls if late or absent			
	Rarely or never absent			
Respects Self & Others	Tells the truth			
	Respects others' belongings			
	Accepts constructive criticism			
Appearance	Good personal hygiene			
	Wears appropriate clothing			
Communication	Able to follow directions			
	Asks appropriate questions at appropriate times			
Interpersonal Skills	Has appropriate social behaviors			
	Works well with others			
	Able to handle peer pressure			
Use of Transportation	Able to get to work area from drop off point			
	Able to get to pick up point from work area			
Flexibility	Adjusts to changes in assignments/circumstances			
	Able to learn new, related tasks			
Takes Pride in Work	Does careful and accurate work			
	Attempts to correct mistakes			
	Takes initiative to do additional tasks			
Job Productivity	Handles equipment and supplies carefully			
	Knows and follows the rules of the job			
	Stays on task			
	Adequate speed			
	Adequate endurance			
Comments				

INTEREST INTERVIEW

To be completed by parent interviewing young adult.

1. What do you like to do in your spare time?

2. What do you enjoy doing?

3. What shows or movies do you like?

4. What chores do you like to do around the house?

5. Do you do them on your own or do you need to be reminded?

6. What jobs that people do when they are done with school look interesting or fun to you?

7. Look at the list you wrote above and talk about what seems interesting or fun about the jobs.

8. What jobs do you know you would NOT like to do?

9. What about those jobs makes you NOT want to do them?

10. What classes have you liked best in school? What about them did you like?

11. What classes DIDN'T you like? What about them didn't you like?

12. How active are you? How much do you move around?

13. Would you rather be inside or outside?

14. Would you be willing to work when it is: (yes or no)

____cold	____dirty	____crowded
____wet	____little space	____clean
____hot	____open space	____in a team
____dangerous	____by yourself	

15. If you've had a job that you liked, what did you like about it?

16. What job or career would you choose now? In the future?

17. What can you do now to help get ready for the job or career you listed above?

CLASS: USE THE FOLLOWING WORKSHEETS: PARENT/FAMILY TRANSITION FORM, THINKING ABOUT THE FUTURE, SKILLS ASSESSMENT, AND THE INTEREST INTERVIEW IN PREPARATION OF COMPLETING YOUR OWN TRANSITION TIMELINE FOR YOUR YOUTH. WE WILL FILL IT IN NEXT WEEK!

BEFORE: PARENT/FAMILY TRANSITION ASSESSMENT FORM

Dear Parents:

As your son or daughter moves closer to graduation, it is important to begin to plan for his/her future. At the next staffing we will develop a transition plan. The transition plan will identify future goals for your son/daughter and ways to support him/her in reaching these goals. We would all like to see all our students become productive members of society. Your input and involvement is critical. Please take a few minutes to complete this Transition Assessment. Think of your son/daughter as an adult after graduation and identify your dreams/goals for him/her.

CAREER/EMPLOYMENT

I think my son/daughter could work in:

- ☐ Full time regular job (competitive employment)
- ☐ Part time regular job (competitive employment)
- ☐ A job which has support and is supervised, full or part time (supported employment)
- ☐ Military Service
- ☐ Volunteer work
- ☐ Other:_____

My son/daughter's strength in this area is:

My son/daughter seems to be interested in working as…

When I think of my son/daughter working, I am afraid that…

To work my son/daughter needs to develop skills in:

EDUCATION:

Future education for my son/daughter will include:

- ☐ College or University
- ☐ Community College
- ☐ Vocational training
- ☐ On-the-job training
- ☐ Personal development classes
- ☐ Other: _____

My son/daughter's educational strengths are:

To attend post-secondary training my son/daughter will need to develop skills in …

RESIDENTIAL/LIVING:

After graduation my son or daughter will live:

- ☐ On his/her own in a house or apartment
- ☐ With a roommate
- ☐ Supervised living situation (group home, supervised apartment)
- ☐ With family
- ☐ Other: _____

My son/daughter's strength in this area is:

When I think about where my son/daughter will live I am afraid that…

To live as independently as possible my son or daughter needs to develop skills in:

RECREATION AND LEISURE:

When my son/daughter graduates I hope he/she is involved in:

- ☐ Independent recreational activities
- ☐ Activities with friends
- ☐ Organized recreational activities (clubs, team sports)
- ☐ Classes (to develop hobbies, and explore areas of interest)
- ☐ Supported and supervised recreational activities
- ☐ Other:_____

During free time, my son or daughter enjoys:

My son/daughter's strength in this area is:

When I think of the free time my son or daughter will have after graduation I am afraid that…

To be active and enjoy leisure time my son or daughter needs to develop skills in:

TRANSPORTATION:

When my son/daughter graduates he/she will:

- ☐ Have a driver's license and car
- ☐ Walk or ride a bike
- ☐ Use public transportation independently (bus, taxi, train)
- ☐ Supported transportation (family, service groups, car pool, special program)
- ☐ Other:_____

My son/daughter's strength in this area is:

When I think of my son/daughter traveling around the community I worry about…

To access transportation my son/daughter needs to develop skills in …

Review the following items. Please identify 3 to 5 areas only.
My son or daughter needs information/support in the following areas:

SOCIAL/INTERPERSONAL:

- ☐ Making friends
- ☐ Setting goals
- ☐ Family relationship
- ☐ Handling legal responsibilities
- ☐ Other: _____
- ☐ Handling anger
- ☐ Communicating needs/wants
- ☐ Relationships with the opposite sex
- ☐ Counseling

PERSONAL MANAGEMENT:

- ☐ Hygiene
- ☐ Safety
- ☐ Mobility
- ☐ Domestic skills
- ☐ Money Management/budgeting
- ☐ Time/time management
- ☐ Personal Care
- ☐ Other: _____

HEALTH

- ☐ On going care for serious medical condition
- ☐ Information on drug abuse
- ☐ Other: _____
- ☐ AIDS awareness
- ☐ Sex Education

THINKING ABOUT THE FUTURE:
A Transitional Planning Worksheet

Defining Your Vision

1. What are your greatest dreams?

2. What are your greatest fears?

3. What things might stop you from reaching your dreams?

4. How can service providers/schools help you reach your goals?

5. How can your family and friends help you reach your goals?

Thinking About Education after High School

1. Does reaching your dream include more classes or school after high school?

2. How will the classes you are taking now help you reach your goals?

3. Do you want to attend college or vocational training? How will it help you reach your dreams?

4. What skills could you learn in school before you graduate that would help you reach your goals?

5. How will you pay for college or vocational school?

6. What support services will you need to attend school after you graduate? (Interpreters, readers, accessible dorms, audio texts, etc.) How do you feel about using these services?

Thinking about Employment

1. What job would you like to be doing in a few years?

2. What are you good at? (Think of something that might be used in a job.)

3. What things are hard for you? (Think of something that some jobs might need that would make that job hard for you.)

4. What things are important to you in a job? (making a lot of money, insurance, times and days you work, close to home or a bus route, etc.)

5. What do you like to do and interest you that you might be able to use in a job in the future?

6. How can service providers help you get a job? How can family members and friends help you get a job?

Thinking about Living Arrangements

1. What sort of house or apartment do you see yourself living in in the future?

2. What jobs do you do around the house or yard that will prepare you for living in your own place?

3. Are there any classes at school or in the community that you could take to help you take care of your own apartment? (cooking, gardening, plumbing, etc.)

4. Would you like to live alone or with someone else?

Thinking About Making and Managing Money

1. How much money do you need to reach your goal? (apartment, bills, car, bike, etc.)

2. How do you keep track of your money? How will you keep track of it when you live on your own?

3. How can you find out about classes is school or in the community that teach ways to take care of your money?

4. Do you know about Social Security? Medicaid? Do you know how to apply for these services?

Thinking About Being Part of the Community

1. What support services are available in the community?

   _____ public transportation
   _____ community recreation
   _____ counseling services
   _____ independent living center
   _____ accessible medical center
   _____ support groups

   Who can help you find out about these services?

2. What sort of volunteer service programs exist that you might want to help out with? (Humane Society, wildlife preservation, Big Brother/Big Sister, Kiwanis, etc.)

Thinking About Fun/Recreation/Relationships

1. What do you like to do for fun?

2. What sort of friends do you have? What do they like to do for fun?

3. What things are most important to you in a friend?

4. What activities do you want to learn to do?

_____ snow ski	_____ make movies
_____ train dogs	_____ hike
_____ swim	_____ write stories
_____ play video games	_____ play team sports
_____ paint	_____ other_____
_____ play card games	_____

5. What new activities can service providers, family, and friends help you learn?

Thinking About Advocacy/Medical Care/Legal Issues

1. Who are your family doctor and dentist?

2. Do you have any specialty doctors? (Orthopedists, psychologists, opthamologists, etc.) Who are they?

3. How would you take care of any medical problems that you might run into?

4. What would you do if you had a medical emergency?

5. What sort of medical insurance do you have?

6. What would you do if you had a legal problem? (you think your rights are not being given to you, you have a problem with the police, etc.)

7. Who would you talk to if you had a question about whether something done to you was against the law?

SECTION 7: TRANSITION TIMELINE CELEBRATION!!!

Each member of the class should bring a food item to share.

The worksheets from previous week should be completed so the Transition Timeline Checklist can be filled out. Using this as a guide, the members of the class will have this opportunity to develop your own timeline and transition plan.

After the Activity of filling out the Transition Timeline Checklist, have a CELEBRATION, eat, read the poem, and give out certificates.

ACTIVITY: GUIDE THE CLASS IN AN EXERCISE TO DEVELOP THEIR OWN TIMELINE.

TRANSITION TIMELINE CHECKLIST

STUDENT AGE	ACTION NEEDED	BY WHOM	BY WHEN
	JUNIOR HIGH		
12 – 15	Include the following areas in IEP meetings: social skills, communication, functional math, functional reading, self-help skills, self-advocacy skills		
12 – 15	Develop and use a plan to increase responsibilities and independence at home		
14+	Obtain official identification card at the Driver's License Bureau, school or bank		
14+	Initial transition meeting as part of the IEP process Begin transition-related assessment process -identify vocational interest/abilities -identify vocational support needed Include activities such as -career exploration -job sampling -introduction to vocational training		
14+	Teach student to use public transportation		
14+	Begin the process of identifying community services that provide job training and placements		
15	Prepare job placement file with references and descriptions of acquired skills		
15	Initiate application to adult services agencies with lengthy waiting lists (i.e., DSPD)		
15	Consider summer employment/volunteer experience		
	SENIOR HIGH		
16 – 18*	Contact Adult Service Programs:		
	1. Education and training (postsecondary)		
	2. Social Security disability programs (includes Medicare and Medicaid		
	3. Residential Services		
	4. Vocational		
	5. Recreational/Leisure Activities		
	6. Medical		
16	Make certain transition-related assessments and goals are part of the IEP		
16+	Investigate the need for a driver's license		
16-18*	Begin job-training at community sites and/or through Vocational Education Programs		
17	Begin to consider and research guardianship		
17	Review of IEP Transition Plan		
17-18*	Take ACT and SAT tests if applicable		

17-18*	Complete applications to colleges or other Postsecondary training if applicable		
18*	Develop a resume		
18*	Update transition-related assessments and goals on IEP		
18*	Establish needed health benefits		
18*	Develop long-term financial support plan		
18*	Update postsecondary plan in cooperation with adult service agencies to determine:		
	- Vocational direction		
	- Living arrangements		
	- Transportation needs		
	- Social/recreational/leisure needs		
	- Medical/health support		

- Depending on extent of disability, some students will have until their 22nd birthday to accomplish transition goals.

Certificate

ALLIES WITH FAMILIES

Utah Chapter of the Federation of Families for Children's Mental Health

Growing Up Without Growing Apart:

Finding your way to your child's adulthood

This is to certify that

_____

Has completed "Growing Up Without Growing Apart: Finding your way to your child's adulthood (date)

_____ _____

Ode to the Parent of an SED Child

The developmental milestones, the struggles, and finally the letting go,
This text has just the beginning of what you'll need to know.

Heart ache, heart break, possible seizures, and even threats of suicide,
You do what you can, learn more, and stand always by their side.

You smile, and you cry, sometimes not knowing where to turn,
Some think, how to give more discipline is all you need to learn.

Anger spurts, sibling issues, insurance forms and bills,
Not to mention therapy, hospitals and so many pills.

Sometimes the pressure mounts, and for the times you yell, you will do penitence.
George Washington didn't have this much trouble, with the Country's independence.

There's IEP's, 504's, and Person Centered Planning.
No one seems to know, you'd much rather be tanning.

All day, there are meetings, groups, educating case workers and even more,
Then with that darned token economy, tonight, you'll be supervising a chore.

Along with taking care of yourself, it never is quite done,
So remember along the pathway of life, one must take some time for fun.

Then when you're almost finished, just when you think you've made it through,
You're not sure if you're still parent, or the SED person is really you!

We hope you've learned and laughed and enjoyed these classes,
'Cuz, it's to YOUR success, that we really raise our glasses.

Nancy Dollmeyer, Parent
Family Advisory Council

SECTION 8: FOSTER CARE

What is "foster care" or "out-of-home placement"?

Foster care is 24-hour care provided by the child welfare system for children who need to move out of their own homes temporarily. If your child moves into foster care, she may live in one or more different types of placements, such as the following:

- Kinship care (Placement with relatives)
- An emergency shelter
- A foster family home
- A therapeutic foster home
- A group home
- A residential treatment center, or
- An independent living arrangement for older youth.

Many places use the term "foster care" when referring to any out-of-home placement.

Why would my child be placed in foster care?

Here are several possible reasons:

- *If the court determines that your child was abused or neglected in your home* by a parent or caregiver, it may transfer custody to the child welfare agency so that your child can live somewhere else. Generally, placement in foster care is temporary and intended to give you time to make the changes necessary for your child to live safely in your own home.

- In some states, *you might decide to place your child in foster care through a short-term, voluntary agreement* with the child welfare agency. You might do this for a specific reason, for example, if you entered inpatient

hospital care for a short period and had no one who could care for your child during that time.

- *If your child has a very serious emotional disturbance or disability, you might turn to the child welfare system* to provide and fund the services your child needs. This happens sometimes when parents have exhausted all possible community-based services that they can afford, and they cannot find or pay for intensive treatment services for their child. Several states have found ways to help children get intensive treatment services without involving the child welfare agency.

- *If you or someone else thinks that your child's behavior is beyond your control, the court can be petitioned to order services for your child and family.* Examples of out-of-control behavior include running away, refusing to go to school and serious substance abuse problems. Utah allows placement in foster care for this reasons. The terms that are used to describe children and youth who fall into this category is ungovernable.

Who are the people who will take care of my child?

- They might be a *relative (kinship care) or a close friend.* This can happen if you have suggested it, and the relative and the agency and/or court agree that it is a good plan and a safe placement for your child.

- They might be a *foster family* that you may not know. All foster parents must meet certain standards set by the state to help ensure that children will be safe and cared for. Most foster parents have been trained to understand the special needs of children who live away from their families.

- They might be *staff who work in a group or residential setting.* Group care facilities must be licensed, and staff must meet standards set by the state.

What information do I need to give to the child welfare agency about my child?

You know your child better than anyone else. When your child is being placed in foster care, it is very helpful for you to share important information about her with the child welfare agency and the people who will care for her. It is important to provide information about the following:

- Your child's daily routine and special needs (e.g., what food your child likes/dislikes)
- School placement and progress
- Your child and family's medical history
- Special care your child has received or needs
- Upcoming medical appointments
- Names of health care providers your child uses
- Allergies your child has
- Medications your child is taking
- Special treatment for developmental or behavior problems
- Information about your child's close friends
- Names of family members and close friends who can help
- Anything else that will help meet your child's needs and make the adjustment to a new home easier

Before you give any original documents, be sure to keep a copy. When your child returns home, all original documents that you shared with the child welfare agency should be returned to you.

Who advocates for the best interests of my child?

Someone will be appointed to represent your child's best interests. This could be any or all of the following:

- A guardian ad litem (GAL),
- A separate lawyer for your child, or
- In some states a court appointed special advocate (CASA).

What is a guardian ad litem?

Federal law requires states that receive federal funds for preventing child abuse and neglect to provide your child with a guardian ad litem. This is usually, but not always, a lawyer. Sometimes a trained volunteer acts as a GAL. The GAL will be a different lawyer from yours. The GAL's job is to meet with your child and to tell the court what he believes is best for your child. The GAL may ask you questions about your child and about yourself.

What does independent living mean?

Independent living refers to a type of placement and also to a type of service for youth who become adolescents in the foster care system.

Independent Living Placement – Older youth who leave the foster care system to live on their own move into independent living situations, for example, an apartment. This includes youth who leave foster care who do not return to their own families, are not placed with relatives or guardians, and are not adopted. Some older youth, who are still in state custody, also live in independent living placements.

Independent Living Services – These services are provided by child welfare agencies for youth in foster care to help them prepare to live independently. They often focus on skill areas such as the following:

- Money management
- Locating housing
- Transportation
- Career development
- Job hunting
- Maintaining employment
- Daily living skills
- Communication skills.

Other support services such as financial aid, health and mental health services, substance abuse prevention, and education or training are intended to help youth live independently. Services to prepare for living independently are most helpful when they begin at an early age.

When is a youth considered an adult and ready to leave the foster care system?

Some youth in foster care move into independent living because they are too old to remain in foster care. This is called "aging out." The age when this happens depends upon what state you live in. In some instances, youth can remain in foster care to age 21. To stay in foster care until age 21, a youth usually has to be involved in a training or an education program (such as technical school or college), have special needs, or live in a special treatment facility.

Will the child welfare agency help prepare my youth for independent living?

Yes. It is very likely that the agency will offer independent living services. A federal program, the Chafee Foster Care

Independence Program, makes resources available to states to support youth who live independently. Utah currently has a transition to adult living task force that is focusing on preparing youth for independent

If the agency offers independent living services to my youth, does this mean it will not try to find a permanent home for him?

No. A decision to provide independent living services does not relieve the state from trying to make reasonable efforts to find a permanent home for any youth.

If my youth receives independent living services, can he still return home?

Yes. The law says that independent living services should be seen as services to help young people transition to adulthood regardless of where they live when they leave foster care.

How many youth leave foster care to live independently?

About 19,000 youth nationwide and approximately 200 in Utah leave the foster care system each year because they have reached the age of 18 and are expected to support themselves.

How can I help make improvements in the child welfare system?

Families are encouraged to express their views on how the child welfare system is working. When you feel that you are ready, you can start by asking the agency worker if there is

an opportunity to fill out a satisfaction survey or to participate in a focus group. You can express your interest in becoming a member of an advisory group that meets with agency staff.

Allies with Families is a statewide family organization that you can join. As a member of Allies, you will have a group voice. Allies with Families offers support, education and training to families and advocates for improvement in service systems.

R E S O U R C E S

Allies with Families
Utah Chapter of the Federation of Families for Children's Mental Health
450 E. 1000 No., #311
North Salt Lake, Utah 84054
(801) 292-2515
(801) 292-2690 FAX
awfamilies@msn.com

Bibliography for Foster Parents:

A Family's Guide to the Child Welfare System: A Collaborative Effort Among the National Technical Assistance Center for Children's Mental Health at Georgetown University, Center for Child and Human Development; Technical Assistance Partnership for Child and Family Mental Health at American Institutes for Research; Federation of Families for Children's Mental Health; Child Welfare League of America, and the National Indian Child Welfare Association.

Sample Family Court Checklist
On Educational Status of Children in Foster Care

When to Use the Checklist: This checklist should be completed at least twice each year, at the end of the fall and spring school terms. It should also be completed each time a change in placement is made.
How to Use this Checklist: A caseworker or case planner should complete the form. A supervisor or Family Court judge should check each item if the answer is satisfactory, or place an X by any item that suggests that the child's educational needs are not being met.
Who is the Person Responsible for School Contact: It may be the foster parent, the birth parent, or any other responsible adult able to review the child's school work, attend parent-teacher conferences, and help the child and teachers when problems arise. This person should be designated at the time of any placement or change in placement.

	In what school and grade is the child enrolle3d (not including summer school?	School: Grade:
	In what month and year did the child enter this school?	Date:
	What enrichment, gifted, tutoring, after-school, summer school, bilingual, or special education services is the child receiving?	List services:
	What is the date of the latest report card in the child's case record?	Date:
	Based on the latest report card, how many times was the child marked late or absent in the last marking period?	Number of days late:
	In how many classes is the child doing work at grade B (80; 3-4) or better?	Number of classes:
	In how many classes is the child doing work at grade D (65; 1-2) or lower?	Number of classes:
	What was the date of the last parent-teacher conference, and who attended for the child?	Date: Name:

Person Chiefly Responsible for Child's Schooling: _____
Relationship to child: _____
Contact Phone Number: _____
Person Completing Right-hand Column: _____
Position/Agency: _____
Contact Phone Number: _____
Date Completed: _____

Seven Questions to Ask at Parent/Teacher Conferences

1. How is my child doing?

2. What are my child's strengths and weaknesses?

3. What are the academic standards for the grade?

   Is my child meeting them? If not, what can we do to help?

4. Is my child experiencing any difficulty of which I should be aware? If so, what?

5. Has my child completed all required work to date? What is he or she missing? Can the work be made up?

6. What tools are being used to prepare my child for the standardized tests? How can we build on this at home?

7. Do you think my child will meet the academic standards necessary for promotion in June? What services are available in the school to help my child? What other resources are available? What can I do to help?

How to Help Your Child with Homework

Parents play a crucial role in encouraging their children to study and learn. Here are tips on ways you can help your child:

- Teach your child to organize, prioritize, and set goals.
- Provide an environment conducive to study. Eliminate as many distractions as possible.
- Remove barriers and don't accept excuses.
- Make homework time part of the regular family routine.
- Encourage your children to do their own work. Don't let them copy (cheat) and don't do homework for them.
- Show your child how you remember and meet deadlines.
- Teach your children memory tricks.
- Let your children see how you do the homework required by your job.
- Pay attention to whether or not your child is keeping up. Check with teachers if necessary.
- Teach your child to break down big assignments into manageable tasks and take one step at a time.
- Help your child understand his/her learning style.
- To the extent possible, provide your child with the tools for study (paper, pencils, dictionary, computer, etc.)
- Discuss current events as a family.
- Practice listening skills as a family.
- Praise efforts as well as results.
- Encourage your child to take risks and try new things.
- Celebrate successes; don't nit-pick or expect perfection.
- Don't threaten or offer bribes.

WHAT TO BRING WHEN REGISTERING A FOSTER CHILD FOR SCHOOL

MUST ABSOLUTELY HAVE:

1. The child

SHOULD HAVE:

1. A letter to the school with the non-parent's name, home address, telephone number, name(s) of parent or guardian of the student with their home address and telephone members, the circumstances under which the student came to reside with them, and the duration of the stay.
2. Proof of address:
   a. Utility bill
   b. Or, deed to a house
   c. Or, document from City Housing Authority or Human Resources Administration
   d. Or, medical insurance cards
   e. Or, statement that verifies the address from an employer, a social agency, a community based organization, or a religious institution

HELPFUL TO HAVE:

1. **Certification of child's name:**
   a. Birth certificate
   b. Or, baptismal certificate
   c. Or, passport
2. **Proof of Immunization:**
   a. 4DTP's
   b. 4 Polio
   c. 1 MMR after 1 year old
   d. 2nd MMR 30 days after 1st and after 15 months
3. Child's IEP (Individualized Education Plan) regarding special education placement.
4. Report card from previous school with school ID#
5. Attendance record from previous school with school ID#
6. Knowledge of child's previous class placement: special education, general education, gifted class
7. Name, place, and address of previous school

SAMPLE LETTER

Dear School Principal:

The below-named student is in foster care and is currently placed with the agency listed in the attached document. We are requesting that s/he be enrolled in your school as quickly as possible. The Department of Education and the Administration for Children's Services are committed to working together to ensure that all the children in foster care are getting the best education possible.

The child must be enrolled regardless of whether s/he has the required documentation, or before an investigation of her/his school history is completed. If there are any issues related to the adequacy of the documentation presented, an investigation is to be conducted after the admission has been completed.

The foster parent or agency named in the attached form as day-to-day responsibility for the care of this child. The foster parent and parent should be invited to parent-teacher conferences, IEP meetings, and any other school business pertaining to the performance of the student. We strongly encourage you to reach out to these parties and include them in the child's educational process. In some cases, however, interaction between parent and child is either limited, or prohibited, by the court. For further clarity in these situations, school staff can refer to the attached copy of the portion of the court order which covers visitation.

ACS would like to invite staff and administrators from your school to get involved in the case conferences pertaining to the child. The case conferences, which occur at regular intervals, serve as a forum for sharing information related to the safety and protection, as well as the functioning of the child and his or her family. School staff can add a valuable perspective to these meetings and we encourage your participation.

The fact that this child is in foster care is strictly confidential and should be revealed to school staff on a need-to-know basis. We appreciate your sensitivity to this issue.

Sincerely,

SAMPLE
SCHOOL-RECORD RELEASE

To: _____

_____

_____

_____

I authorize you to release to the Administration for Children's Services any and all records, including but not limited to, the cumulative record folder and all its contents, all academic records, guidance reports, anecdotal records, incident reports, attendance records, immunization and health records, special education records (if any), and any other records maintained by the school; and also including any records kept by the guidance counselor.

The right of confidentiality means that you cannot share information without my consent. I fully understand that I am requesting that you share confidential information with the Administration for Children's Services. Please honor my request as quickly as possible.

_____ _____
Name of Child Signature of Parent/Date

_____ _____
Date of Birth Address

Send documents to: _____
Name/Title

_____
Address

SAMPLE

Caseworkers can copy this form on agency letterhead and give it to the adult who is registering a foster child for school.

Child: _____

DOB: _____

Student ID: _____

CIN (Medicaid #) _____

Address: _____

Previous School: _____

Current Grade: _____

Check one:

General Ed _____ Special Ed _____ Gifted Program _____

Foster Care Agency: _____

Caseworker/Contact: _____

Phone Number: _____

Parent(s): _____

Phone Number _____

Address: _____

Foster Parent(s): _____

Phone Number: _____

Date of Placement with Foster Parent: _____

Interaction with Parent (circle one):

Permitted Limited Prohibited

Date of Court Order (if applicable): _____

Other Relevant Information:

SAVE THE DATE!
Save the Date

Parent-Teacher Conferences

Spring 2005
Please be aware of these dates for parent-teacher conferences this spring. We strongly encourage all foster parents to make arrangements to meet with their children's teachers.

MIDDLE SCHOOL
Wednesday, February 27
Thursday, February 28

ELEMENTARY SCHOOL
Wednesday, March 13
Thursday, March 14

HIGH SCHOOL
Thursday, April 11
Friday, April 12

Be sure to check with school for exact date and times.

Sample Memorandum from Board of Education

TO: All Superintendents and Principals
FROM: School Board Member
RE: School Registration of Children in Foster Care
DATE:

Regular attendance is, of course, among the most significant components of success in school. The increasing mobility of our student population has placed ever-greater importance on the capacity of our schools to facilitate the transfer and registration process. This is particularly true for students in foster care, who may be subject to more frequent changes of location and circumstance.

It is imperative that every effort be made to facilitate a smooth and efficient registration process for students who are in foster care. These youngsters will generally be accompanied for registration either by an employee of the Administration for Children's Services, by an employee of a private foster care agency, or by a foster parent. It is important that every consideration be extended in these situations, and that the student be registered as quickly as possible. If there is any question concerning documents being provided, or documents that may be missing, school staff should, in accordance with the Utah State Office of Education regulations, immediately register the student on a provisional basis and request that follow up information be provided as promptly as possible. If the student is attempting to register in the wrong school, the student's accompanying adult should be directed to either the appropriate school or to the district office. Either way, a telephone call should first be made to the school or district office to which they are being directed, to ensure that it is the correct place and to let the office know to expect the student.

It is our goal to provide every possible support and encouragement to children who are in foster care. A warm, welcoming and efficient registration process will create a lasting impression, and help us to serve these students to the utmost of our ability.

Thanks you for your cooperation concerning this important manner.

SCHOOL REGISTRATION:
Where and When

First Day of School

September 5, 2005 (High School Only)
September 6, 2005 (Elementary & Middle School)

ELEMENTARY AND MIDDLE SCHOOLS

When: Beginning August 27, 2005 and throughout the school year
Where: At the child's zoned school

HIGH SCHOOLS

When: August 27 – August 31, 2005
& January 28 – February 1, 2006

Where: High School Registration offices

When: All other times of the year
8:00 a.m. to 2:00 p.m. – Monday – Friday

Where: Admissions office at the youth's zoned school

FOSTER CHILDREN & EDUCATION

A Publication of the Vera Institute of Justice

Recognizing the Challenge: How are foster Children Doing in School?

Foster children lag behind their non-foster peers in school. Research over the past three decades has shown that, compared to the general school population, the half-million foster children in the United States:

- Have poorer attendance rates,
- Are less likely to perform at grade level,
- Are more likely to have behavior and discipline problems,
- Are more likely to be assigned to special education classes, and
- Are less likely to attend college.

A 2001 study in the American School Board Journal found that foster children often repeat a grade and are twice as likely as the rest of the school population to drop out before graduation. And among all students who drop out of school, fewer foster children eventually earn their GED than non-foster dropouts.

The old assumption that foster children suffered from the same barriers as other economically disadvantaged children suggested that the only solution was to improve the school experience for all poor children and that there was nothing the child welfare system could do. But this recent research and our own experience in developing Safe and Smart suggest that child welfare professionals can address many of the special challenges that foster children face.

Obstacles to Education Success

No adult in the foster care system wants children to do poorly in school; they often just don't think about school very much. When we talked with foster children, many told us that the only time their foster parents, caseworkers, judges, or lawyers paid attention to how they were doing in school as when they were misbehaving or failing to attend. And sometimes they did not get noticed by the adults around them even then. School is forgotten or treated as a side issue as the adults worry about protecting children from neglect or abuse, finding them new homes, or transferring them if a placement does not work out. So the first challenge is to pay attention and to look at the special obstacles foster children face in trying to get an education, many of them inadvertently created by the adults.

Lack of Continuity in Education

For children in care, placement – and subsequent changes in their foster care residence – often means a change of school as well. Most research shows that transfers have a harmful effect on educational outcomes. The absence of required school records or other documents can lead to a delay in registering at the new school and a gap of days or weeks

in learning. But less recognized is the effect of placement transfers on the child. Each transfer requires the child to adjust to new teachers and peers and to a curriculum that may differ considerably from her previous school. Too many transfers can cause a child to disengage and give up on school. Transfers also play havoc with continuity of special services. Many jurisdictions are now making it a priority to keep children in their present school both when they enter care and if they experience multiple placements. Keeping school as a point of stability can help foster children succeed educationally and give them peers and caring adults to help them weather the changes at home.

Requirements of the Child Welfare System

The foster care system makes many demands on those who are part of it, including the children. There are court appearances, sessions with counselors and therapists, and medical appointments that frequently conflict with school. Children in care miss tests and homework assignments because of scheduling conflicts and, therefore, fall behind in their school work. Judges and caseworkers should make it a priority to schedule appointments after school hours.

Lack of Emphasis on Education

If the systems responsible for the well-being of foster children – child welfare, education, and the courts – do not place a strong emphasis on the education of foster children and work together to promote success in school, education will fall through the cracks. Education planning should be a part of the initial discussions about placement when a child enters care and whenever that placement changes. Here is an excerpt from one plan:

> *All the children should remain at their current school. They seem to be doing very well academically with no reported problems and as a result, it would be in their best interest to continue at that school.*

The courts have a role to play, too. Judges can raise the question of the child's education during all Family Court hearings. They can hold child welfare agencies and schools responsible for meeting the child's educational needs. Joseph M. Lauria, administrative judge in the Family Court of the City of New York, suggests that "the education issue should be raised every time" a case is heard in court.

Low Expectations

All children respond to expectations, and when the adults in their lives expect them to do poorly, they often fulfill those expectations. Too often teachers, guidance counselors, and other school staff do not expect foster children to excel in school. Even foster parents, some of whom may have little formal education themselves, and caseworkers may expect nothing more than passing grades. Few foster children are encouraged to think about college; they are much more likely to be directed to vocational education programs. And few are encouraged to participate in the extra-curricular activities that are

associated with higher academic achievement. Yet recent studies of older youth in foster care show that they often have high educational aspirations, resent the fact that more is not expected of them, and would benefit from adult encouragement.

An Absence of Advocates

Children in foster care generally do not have an adult who is their educational advocate – someone who know her way around the school system; helps navigate the registration and transfer process; monitors grade and attendance reports, and makes sure that the child is properly tested, placed in the appropriate grade, and receiving the necessary services. For most non-foster students that advocate is a family member, usually a parent. Foster children have lots of adults responsible for their care – but no one person responsible for their education. While growing number of advocacy organizations are promoting the education of foster children and raising awareness of its importance, general measures are not sufficient. Every foster child needs a designated adult to act as that child's individual advocate. That person not only can intercede with the school system on the child's behalf but can offer the encouragement a child needs to achieve his educational aspirations.

The Stigma of Being in Foster Care

Many foster children do not seek help or engage in the social relationships that contribute to a positive educational experience because they are ashamed of being in care. When a Vera Institute researcher asked a middle school boy if any of his fellow students knew he was in foster care, he replied emphatically, "I hope not!" The children may become socially isolated and withdrawn as a way to avoid embarrassment or to shield themselves from teasing and bullying. Much of the research that focuses on direct experiences of youth in care has been conducted in Britain. A study of foster children in residential homes in England found that many did not attend school because they felt harassed by other students. "They pick on me for being in there," one student reported. "They say, 'At least I'm with me mum and dad, and you're in a home."

The Burdens of Past Experience

Some children enter foster care already behind in school because of abuse or, more often, neglect. The neglectful parent may have failed to register the child in school or, more commonly, did not encourage or may have discouraged attendance. The children we interviewed talk about missing school in order to care for younger siblings. Recent research also suggests that children entering foster care have more medical issues than their non-foster peers, and illness may have prevented them from attending school. Whatever their experience before entering care, removal from home and separation from parents and siblings can have serious psychological and emotional consequences, which may be manifested in appropriate behavior at school. Some children will act out; others will withdraw. Concerns about birth parents and worry about siblings from whom they have been separated can be distractions that keep the children from focusing on their school work. Studies suggest that the combination of pre-placement experiences and

placement itself has a detrimental effect of both academic performance and behavior in school.

The Gap between the Systems

Researchers generally cite a lack of coordination between the child welfare and educational systems as an underlying obstacle to helping foster children succeed in school. But the gap between the two systems is wider than simply a lack of coordination. In many instances there is a fundamental lack of understanding of how the other system works and a lack of time to focus on the educational needs of the children.

Caseworkers must of necessity devote their primary attention to the safety of the foster children in their care, making sure that the children have secure homes and are not neglected or abused. Even those caseworkers who want to take a greater role in the educational lives of the children usually find that their heavy caseloads and mountains of paperwork leave them little time to focus on school matters. And if they manage to overcome those challenges, they still may be frustrated by a Byzantine educational bureaucracy that has little knowledge of the child welfare system.

On the other hand, school officials – especially classroom teachers – are often unaware of which students are in foster care. Without the social history of the child, staff may not recognize the reasons behind aberrant behavior or may place a child in special education unnecessarily. Staff may be confused about which adult has guardianship of the child or whom to call when academic or behavioral problems arise. They complain that foster parents and caseworkers show little inclination to learn about the child's progress in school. And recent pressure on schools to show gains in standardized test scores may mean they are less likely to make the extra effort to help children in foster care who lag behind academically.

In response to the growing awareness of this communication gap, a number of efforts are underway to increase coordination between the educational and child welfare systems:

- In Illinois, the Center for Child Welfare and Education, a partnership between Northern Illinois University and the state's Department of Children and Family Services, trains foster parents to be advocates for the education of the children in their care. More than 18,000 foster parents have received the six-hour training.

- Many foster care agencies employ an education specialist to help foster children and their guardians maneuver the school system and to act as a go-between for the two systems. Their duties vary considerably across agencies, with funding precarious; some agencies are eliminating the position. In New York City fewer than half of the contract agencies have such a staff person.

- San Diego County, California, was the first jurisdiction to adopt a Health and Education Passport, a record of a foster child's educational and medical history that travels with him from placement to placement and school to school. The

passport includes such information as the child's immunization record, schools attended, grade level and performance, attendance record, and special needs. The Washington State Legislature enacted a similar passport system in 1997, but recent reports from both jurisdictions suggest that issues of confidentiality and the absence of procedures for sharing of information have kept the programs from being fully effective.

- Data-sharing agreements hold some promise. If they succeed, both systems can assess the needs of individual children and determine what services are necessary. In New York City, the Administration for Children's Services and the Board of Education developed a data-sharing plan and has been working to implement the plan since 1997. ACS and the Department of Education (successor to the old Board) now hold bi-monthly meetings at which data-sharing issues are discussed. But as we found at Safe and Smart, data sharing is unlikely to be an easy or quick solution to improving educational outcomes for foster children.

The systemic level reforms are promising – but as these examples illustrate, they can be challenging to implement and slow in creating real improvements on the ground for the current generation of children in care. In these materials, we do not want to discourage systemic reform but rather caution against seeing it as the sole solution. Such reforms can be paired with concrete, low-cost, individualized attention to foster children.

Adult Involvement

One of the characteristics that all foster children share is the number of adults accountable for their well-being. Ideally, foster parents, birth parents (if they are still in their children's lives), caseworkers and education specialists in the child welfare system, and school staff all would take a strong interest in a child's educational progress. What's more likely, however, is that a lack of coordination among the adults will result in the educational needs of the child falling through the cracks.

Not paying attention can have serious effects on the child's academic progress. Studies show that all students tend to do better in school when the adults in their lives are actively engaged in their education – attending parent-teacher conferences and work school activities as well as monitoring homework. Because studies also show that children in care experience greater educational deficits than the average child, their need for parental involvement is even greater. Yet they are less likely to have foster parents or guardians who take an active role in their education.

A New York program identified two simple, inexpensive, and complementary steps for strengthening adult involvement in the education of foster children. The first is to assign primary responsibility for monitoring the child's education to a specific individual, while encouraging all adults in her life to follow her progress at school. The second is to

actively promote foster and/or birth parent interaction with the school by emphasizing attendance at parent-teacher conferences.

Primary Responsibility

Making more adults aware of a child's progress at school might improve the chances that one would take responsibility for checking the child's attendance record, picking up report cards, meeting with teachers, and responding to academic or behavioral problems. Making one of those adults primarily responsible for overseeing the child's schooling would more likely ensure that education receives the attention it needs if the child is to succeed at school and later in life.

Confusion about which adult is responsible starts at the beginning of the child welfare placement. Who decides – the caseworker or foster parent or group home staff member of birth parent – where the child should go to school once she enters placement? And if the child needs to transfer schools, who is responsible for enrolling her? School staff often complain that in the case of foster children, they do not know who is in charge. Even signing simple forms – permission slips for field trips, to receive after-school services, or to participate in sports teams – becomes complicated. Many foster children are excluded from activities because foster parents did not believe they had the authority to sign, and caseworkers were too busy to pay attention to such simple tasks. The law itself is confusing: while the birth parent may have erred enough for the state to remove her child, she retains some rights, including the presumption that she is the only person who can consent to special education.

The Role of the Caseworker

Vera's experience suggests that the caseworker must be trained and encouraged to designate which adult will serve as the child's educational advocate – and that judges can play a key role in ensuring that such an advocate is appointed. First, of course, the caseworker must understand the need to pay attention to the child's education. Second, the caseworker is often in a position to understand which adult can best serve as the primary point person. Third, the caseworker often has explicit responsibility for collecting some basic educational information about the children on her caseload.

In New York City, for example, the regulations of the Administration for Children's Services (ACS) require caseworkers to visit the child's school twice a year. In theory, during these visits they can collect report cards and attendance records; meet with teachers, counselors, and school administrators; or even arrange to meet the foster parent at the school for a discussion that focuses strictly on educational issues. In practice, caseworkers report that they struggle with this responsibility. They find many schools to be intimidating and unwelcoming places. Because they are unfamiliar with the school schedule and with school regulations, they show up at inconvenient times and demand report cards and attendance records – but they do not get them. They lack the necessary consents and they do not understand school processes. As a result, some give up while others spend hours trying to decipher the system.

Arming caseworkers with basic information – and tool kits – would be an effective and efficient way to help them meet these responsibilities. But the key is to encourage them to designate responsibility for the child's education to a single adult – the foster parent, the group home staff member, themselves, a specialist – or to turn to the birth parent to serve in this role.

Birth Parents as Advocates

If the caseworker determines that the birth parent is likely to resume custody, she may decide that the parent can best serve as educational advocate.

There are great advantages to having the birth parent be the advocate if she is capable of doing it. Education law pays great deference to the parental role – and as stated above, child welfare placement does not sever those rights. Consequently, the birth parent must be involved in educational decision-making even after placement, particularly if the child has special needs. When a parent refuses or is unable to serve in this role, educational law recognizes the right to appoint a *guardian ad litem* to make educational decisions for the child. But if the caseworker fails to coordinate with the school, special education officials will simply appoint a *guardian ad litem* from an available pool – and yet another adult, one who knows very little about that child, will become officially responsible for the child's special educational needs.

Other Options for the Advocate

If the birth parent cannot or should not serve as the child's primary educational advocate, the caseworker should decide whether she, the foster parent, group home staff person, or some other specialist should be designated. In practice, by default, it is usually the foster parent or group home staff person who takes on this responsibility. Many caseworkers assume that is part of the foster parent's job and that he or she will know what to do and how to do it. But Safe and Smart staff found that, while many foster parents might like to serve in this role, they may have limitations that make them less effective or poor candidates. Some foster parents or group home staff have only limited education themselves and are easily awed or intimidated by the school system. Others are juggling many children in their care and do not have the resources necessary to serve as the educational advocate for every foster child. Others have not received support or encouragement – and certainly have not been held accountable – for paying attention to a foster child's educational needs. But many are capable. They simply need training, support, and encouragement. Given the right information, caseworkers can familiarize parents with the rights of foster children, include education as a topic at regular meetings with foster parents, and teach foster parents how to read report cars and attendance records. With help and training, many foster parents can become educational advocates for the children in their care.

In other situations, the caseworker will be aware that a child has special educational needs and/or that the foster parent, while perfectly capable of providing a safe home, does not have the skill necessary to serve as the child's educational advocate. In these instances, the caseworker herself – or an educational specialist identified by the caseworker – should assume primary responsibility.

In order to encourage the designation of an educational advocate for foster children, the "Checklist on Educational Status of Children in Foster Care" that can be used in any jurisdiction concerned about the education of foster children. The checklist (see handout) asks such basic questions as: In what school and grade is the child enrolled? What services is the child receiving? What are the child's grades? How many times was the child absent or late to school? But most critically, it requires designing the "Person Chiefly Responsible for Child's Schooling" and asks for that person's name, relationship to the child, and a contact phone number. The checklist is to be completed by the caseworker at the end of each school term – or whenever a change in foster care placement occurs – and reviewed by a child welfare supervisor or Family Court judge.

The checklist can serve as a consistent reminder that education is an integral part of placement in foster care. But absent such a formal document, the caseworker still should be encouraged to monitor the child's progress at school – either directly or through a designated educational advocate.

Attendance at Parent/Teacher Conferences

Tackling the whole relationship between education and child welfare can be intimidating, but breaking it down into smaller steps can help. In addition to designating an educational advocate for each child in foster care, child welfare staff can take advantage of some easy points of entry into a child's school life. One obvious and non-intimidating point is parent-teacher conferences. Teachers are available on parent-teacher conference days, and many jurisdictions use these occasions to distribute and discuss report cards and attendance. The obvious answer was to ensure attendance by someone – the foster parent or caseworker – at the child's parent-teacher conference.

Simple training sessions that encouraged caseworkers to mobilize foster parents to attend these conferences can be held. Caseworkers would receive a kit with handouts that could easily be copied for foster and birth parents. The kit included a scheduled of conferences at elementary, middle, and high schools; a sample report card (with guidance on how to read it), and guidelines for helping children with their homework. Recognizing that foster parents with limited education can feel intimidated by teachers and other school officials, or unsure of what information to seek, the kit also suggested seven questions they could ask at the conference including: What are my child's strengths and weaknesses? Has my child completed all required work to date? What can I do to help? The contents of the kit should be printed in both English and Spanish and easily translatable into any language.

Bridging the gap between the child welfare and educational systems serves children well. But constructing those relationships can seem like a formidable task. Starting with simple, inexpensive, and easily implemented solutions can help. The steps discussed here – designating one adult with primary responsibility for educational issues and promoting attendance at parent-teacher conferences – can help to bridge the gap and to ensure that the children's educational progress doesn't fall through the cracks.

Enrollment and Transfers

A change in school is a challenging experience for any child – but for a child in foster care the challenges are even greater. All children changing schools have to adjust to new teachers and counselors, new classmates. There are new classes to attend, classes in which the curriculum may differ significantly from the previous school, and a whole new school environment to decipher. And all of that change proves even harder if the transfer occurs in the middle of a school year.

Foster Children Face Additional Burdens

For foster children, school transfers usually occur at the same time they are adjusting to a new home and new foster parents. Researchers found a number of studies that cited school transfers and delays in registration as reasons why foster children are not succeeding in school. A recent study by the Child Welfare League of America suggests that it takes a child from four to six months to recover academically from the disruption of changing schools. And many children experience multiple transfers during their time in care.

These additional burdens on foster children make it especially important for caseworkers to pay attention to the question of school enrollment. Yet time pressures, high caseloads, a singular focus on safety – and often the scramble to find a bed – can make it difficult for caseworkers to think about the impact of placement on the child's schooling.

Such negotiation can be challenging. If the child is moved out of his school district, the task of registering him a new school can prove overwhelming to whichever adult (caseworker, foster parent, group home staff person) ends up with that responsibility – and the child may miss days or weeks of school.

Placing a Priority on Avoiding School Transfers

For children in care, school can be a place of stability in their otherwise chaotic lives. So the first question to ask is if placement in foster care (or reassignment to a new home within the child welfare system) really necessitates a change in school. Many child welfare agencies around the country, there is a growing preference for keeping the child in her current school – or at least in the same community school district – if possible. There are, of course, circumstances that can make school stability difficult to maintain: The child could be placed in kinship care in another part of the city, for example, or the current school may not be able to meet her special education needs. But in general, if the child is doing well and there are no risks involved in remaining at the current school, strong consideration should be given to continuity of education. Caseworkers and other child welfare staff should be trained and encouraged to regard school transfers as undesirable. And all avenues – including transportation support to enable the child commute to her own school – should be exhausted before embarking on a necessary school transfer.

Not all school changes result from entry into care or change of foster care residence. Transfers can occur if a child is moved because of behavior problems, is placed in a permanent home (reunited with birth parent or adopted), or ages out of the system before graduating.

A number of advocates are urging that the child be included in the decision about where he will attend school. An older child especially may have strong feelings about school choice. He may wish to remain with friends in familiar surroundings or, conversely, he may wish to make a new start in a new setting.

Simple Tools Can Facilitate Necessary School Transfers

If placement results in a change of school, there are several steps a caseworker can take to facilitate the process. A good place to start is with a simple set of tools to navigate what can be a complex education system.

The handouts include a “Back to School” kit for use by caseworkers and foster parents that can be adapted to any school district.

The kit includes:

1. Two letters designed to expedite the registration process. The first is addressed to school personnel and signed by a senior official of the child welfare agency. The letter, to be presented to school staff, asks for – and cites regulations that require – prompt registration of foster children. The second, addressed to superintendents and principals, is from the chancellor (top official) of the school system and emphasizes the role of timely registration in providing “every possible support and encouragement to children who are in foster care.”

Together, the letters show that both the education and child welfare systems place great importance on promptly enrolling foster children in school. They also clarify which education regulations govern the registration process so as to ensure those regulations are applied fairly and consistently to foster youth. Attendees said the enrollment letter was the most useful aspect of the trainings, and several reported that the letter elicited positive responses from school staff.

2. A "What to Bring" list
3. Phone Numbers for key contacts in the school system
4. A school calendar
5. A schedule of parent-teacher conferences.

The "What to Bring" list helps ensure that caseworkers, foster parents, or other adult advocates arrive at the school with all of the documents necessary for registration. The other materials in the tool kit – the school schedule and the dates of parent-teacher conferences – signal that ongoing contact between child welfare staff and the school is expected.

In addition this tool kit can be given to clear up any confusion about guardianship, and a form the guardian signs that allows the school to share information about the child's educational record with the child serving agency involved. These additions reflect an increased understanding of the challenges faced by education officials in dealing with foster youth. School officials have said that there were almost too many adults involved with foster youth – and they did not know who had the authority and responsibility for the child's educational needs. This confusion also spilled over to foster parents, who didn't give permission for a child to attend an after-school program, sign up for tutoring, or participate in a field trip because they assumed they lacked the authority. The guardianship clarifies which adult serves as the primary point person for the school.

Support for Caseworkers

First, caseworkers must know the law and the requirements of the school system. Because policies and procedures vary from one locality to another – and often from one school to another – it is difficult to provide caseworkers with a universal set of rules. But knowing the local rules and regulations can be the difference between successfully enrolling a child in school and a child missing days or weeks of education.

Other Things Caseworkers Can Do:

- Decide which adult will be the point person for that child's education.
- Discuss with foster parents and the child during the summer where the child will be attending school. Although never easy, transfers are less disruptive in summer or during a mid-year break.

- Find out if the school has an enrollment packet with written admission policies and share this information with the foster parent or other designated adult.
- Know when the foster parent or other designated adult is taking the child to school and make sure that she can contact you if she encounters a problem.
- If records are missing, write to the new school asking staff to request records from the child's previous school.

Additional Complexities

Registration is even more complicated when a child who has been placed in a residential treatment center (RTC) or other institutional placement outside of the local school district returns to his home locality and needs to be re-registered in school. Some of these institutions have their own schools or enroll children in a different district – and the home district does not recognize the educational credits or understand how to translate that educational experience and place the child at the appropriate level in school upon return.

The Questions are the Same

But in all cases in which a child in care is entering a new school the questions are the same: When registration problems arise, how are they addressed? And who is ultimately responsible for the child's education – the caseworker, the educational specialist, the foster parent, or the birth parent? Our experience suggests that the most important thing is to acknowledge the importance of school – and then to provide child welfare staff with some inexpensive and easy-to-use training and tools to tackle the challenge of school registration.

Appendix 7

Cultural Competence Practice Model

CULTURAL COMPETENCE PRACTICE MODEL

Developed by
Cultural Competency Advisory Council
Utah Division of Substance Abuse and Mental Health

September 2, 2003

GOAL

Cultural, ethnic and linguistic diversity will play a critical and crucial role in mental health care that results in services that are effective and sensitive; delivered by knowledgeable and skilled clinicians in collaborative manner to assist individuals to achieve personal well-being.

TARGET POPULATIONS

The identified populations are children, youth and adults from historically underserved and underrepresented racial/ethnic minority groups and the Deaf, with an understanding that additional cultural factors include gender, age, language, immigration status, disability, sexual orientation, religion, and socioeconomic status, which run across all groups.

OVER-ARCHING PHILOSOPHY

Culturally competent service delivery evolves out of three areas: a) guiding principles (values and attitudes), b) training, and c) skills. Service providers become culturally competent through education, self discovery, and experience.

A. Guiding Principles (Values and Attitudes):

1. Principle of Respect

a. Recognize the inherent worth of all human being regardless of how different they may be from oneself, including respect of roles of family members and community structures, hierarchies, values, and beliefs within the client's culture.

b. Give value to a client's religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychological functioning, and expressions of distress. This is essential to effective service delivery, even if client's world perspective will increase the care provider's ability to provide meaningful and comprehensive care, regardless of his/her own personal perspectives and values.

2. Principle of Consumer/Family-Driven and Community-Based System of Care

a. Family and community play a significant role in the life of consumers.

b. Consumers and families are the most important participants and collaborators in the service planning, implementation and evaluation process.

c. Family is defined by function rather than bloodlines in many ethnic cultures. Individuals from these groups generally conceive of family much more broadly than mainstream individuals.

d. Self-help concepts from the racial/ethnic/deaf cultures are valued.

e. Familiar and valued community resources from the client's culture are valued.

f. The least restrictive, appropriate and community-based environment for treatment is valued.

3. Principle of Natural Support

Natural community support and culturally competent practices are viewed as an integral part of a system of care which contributes to desired outcomes in a managed care environment. Traditional healing practices are used when relevant and possible.

4. Principle of Sovereign Nation Status

The systems of care for American Indian and Alaska Native who are members of sovereign nations must acknowledge the right of those sovereign nations to participate in the process of defining culturally competent managed care.

5. Principle of Collaboration and Empowerment

Consumers from diverse groups are supported in their desire to collaborate with service systems to determine their course of treatment. The greater the extent of this collaboration, the better the chance of recovery and long-term improved functioning.

6. Principle of Holism

The value of a holistic approach to care is recognized and is implemented in education/prevention/early intervention, clinical work, policies, and standards, recognizing its importance to diverse groups.

7. Principle of Feedback

Legitimate opportunities for feedback from diverse groups are encouraged in order to enhance desired outcomes of their activities. Where such opportunities for feedback are absent, there is a greater likelihood that services will not be congruent with the needs of consumers and will result in lower levels of consumer satisfaction, as well as the agency missing the chance to make culturally specific corrections in its service delivery system.

8. Principle of Outcomes

Meaningful outcomes for consumers from diverse groups and their families are determined by the consumers themselves and should reflect assessment of services relative to the problems that prompted their seeking help.

B. GUIDELINES FOR PRACTICE WITH DIVERSE POPULATIONS:

Goal: Agencies will provide personnel with resources and training to effectively build the knowledge and skills necessary to improve service delivery and quality of care. Knowledge and skills include, but are not limited to, the following:

1. **Knowledge** is gained through workshops, classes, and/or printed materials that:
   a. Enhances understanding and awareness of each individual's personal cultural, moral, and social/cultural values, beliefs, and biases and sensitivity to how these factors may enhance interactions with others or may interfere with promoting the welfare of others. This is an on-going process that requires each employee to constantly reevaluate his/her competence, attitudes, and effectiveness in working with diverse populations.

   b. Emphasizes the power differential between oneself and others in order to diminish differences, and teaches personnel to use power for the advantage of others rather than unwittingly to abuse it.

   c. Develops a knowledge-base of target groups (i.e. those groups identified as living within the geographic boundaries of the agency as determined by demographic data) through the study of group or cultural norms, including specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expression of major client groups, in order to recognize individual differences within the larger context.

   d. Provides an awareness of culture-bound syndromes (i.e. definitions of illness, causation and treatment that are culturally identified and defined) associated with diverse groups and their subcultures, including differences in thresholds of psychiatric distress and tolerance of symptomtology by their natural support systems. Understanding includes knowledge of healing practices and the role of belief systems (religion and spirituality) in the treatment of diverse clients.

   e. Encourages employees to question the applicability of theories or treatment models commonly used may not apply to diverse groups, because they have been developed with research based on people from the dominant culture and therefore, may not apply or differently apply to form non-dominant cultures.

f. Enables personnel to recognize the reality, variety, and implications of all forms of oppression in society, and the impact of discrimination and oppression on the daily lives of individuals from diverse cultures.

g. Provides personnel with information on the services available in the community and broader society for individuals from diverse groups. This information is comprehensive, including names of agencies and available services, location referral procedures, access criteria, etc.

2. Skill acquisition that enable service providers (i.e. any employee of an agency that interacts with clients and/or engages in direct client care, such as counselors/therapists/psychiatrists, etc.) to:

a. Ensures that the client, the client's family, and appropriate support network are engaged as the base system of care in assessment, treatment planning, service delivery and evaluation of services.

b. Utilize the client as a cultural guide, rather than assuming the role of expert. This is accomplished through respect, active listening, and a strength-based orientation, allowing the client to educate the provider about the cultural aspects determining causation, assessment, and treatment of problem. Methods such as Ethnographic Interviewing are extremely helpful in the process. Another effective model is "Strategies for Clinical Cultural Assessment and Interactions," (Miller, 1982).

c. Utilize culturally sensitive interviewing tools, such as Kleinman's (1981) Tool to Elicit Health Beliefs in Clinical Encounters and Pfifflering's (1981) Cultural Status Exam. These methods result in treatment plans that are compatible with the conceptual framework and community environment of clients and family members and are therefore relevant to their culture and life experiences, leading to desired outcomes. Care plans developed in a culturally competent manner include:

i. Family and cultural strength
ii. Traditional healing practices
ii. Religious and spiritual resources
iii. Natural support system
iv. Community organizations and self-help groups within the client's identification/affiliation
v. Coordination and mental and physical health, as well as other source services
vi. Educational components that explain the problems/conditions being treated, treatment methods, concepts of recovery, rehabilitation, prevention, and self-help approaches.

d. Provide, whenever possible, information in writing along with oral explanations, in the preferred language identified by the client at intake and throughout the treatment process.

e. Be, whenever possible, bilingual and culturally competent. When such staff are not available, trained and/or skilled interpreters who are knowledgeable in the mental health field can be used. Use of family member, especially children, is prohibited. Linguistic assistance is made available according to the client's preference from intake to conclusion of services.

f. Ensure that consent is truly informed, keeping in mind diversity issues and cultural/linguistic differences. This requires provider to be especially careful to be open, honest, and straightforward, remembering that persons who are oppressed may be distrustful or overly trustful of those in authority.

g. Be conscious of client's historical and personal experience with oppression and the impact of this on the helping relationship and the treatment plan. As a result, provider assess accurately the source of difficulties, apportioning causality appropriately between individual, situational, and cultural factors.

h. Respect privacy and confidentially according to the wishes of clients, and explains fully any limitations on confidentiality that may exist.

i. Evaluate the cultural meaning of dual/multiple and overlapping relationships in order to show respect and to avoid exploitation of the client. Service provider explains, at intake and through treatment process, potential boundary issues.

j. Seek to understand culturally defined beliefs and/or behaviors that may conflict with the law in the city and/or state in which treatment occurs, and through rapport building helps the client understand and comply with pertinent laws. Such areas may include, but are not limited to, physical or sexual abuse, child disciplinary practices, healing practices, and child rearing practices (which may include the age at which children are left alone, or in charge of younger children).

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APPENDIX

Kleinman, Arthur (1980). *Patients and Healers in the Context of Culture*. The Regents of the Unversity of California, University of California Press.

Kleinman suggest the following questions to elicit an explanatory model:

1. What do you think cause your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?
5. What are the chief problems your sickness has caused you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to get from treatment?

Additional tools for Sensitive Interviewing:

1. Individual or family illness prototypes:
    a. What are your ideas or concerns about your illness based on your previous personal experience?
    b. What are your ideas or concerns about illness based on the experiences of other family members or friends?
2. Individual or family patient requests:
    a. What type of help would you (your family member) like (hope, wish, want) to receive from the practitioner?

Pfifflering, J.H. (1981). *A cultural prescription for mediocentrism.* In: Eisenberg, L., Kleinman, A., eds. The Relevant of Social Science for Medicine. Dordrecht, Holland, D. Reidell Publishers, p. 207

CULTURAL STATUS EXAM QUESTIONS:

1. How would you describe the problem that has brought you to me?

    a. Is there anyone else with you that I can talk to about your problem? (If yes, to significant other: Can you describe X's problem?)

    b. Has anyone else in your family/friend network helped you with this problem?

2. How long have you had this (these) problem(s)?

    a. Does anyone else have this problem that you know? (If yes, describe them, how old they are, and their different presentations/symptoms.)

3. What do you think is wrong, out of balance, or causing your problem?

    a. Who else do you know who has, or gets this kind of problem?

    b. Who, or what kind of people, don't get this problem?

4. Why has this problem happened to you, and why now?

    a. Why has it happened to (the involved party)?

    b. Why did you get sick and not someone else?

5. What do you think will help to clear up your problem?

    a. If they suggest specific tests, procedures, or drugs, ask them to further define what they are and how they will help.

6. Apart from me, who else do you think can help you get better?

    a. Are there things that make you feel better, or give you relief, that doctors don't know about?

Appendix 8

Sample Internal Referral Form

Valley Mental Health - Children's Services
Project RECONNECT/Transitional Services
Referral

Phone 264-2325 Fax 268-1724

Date of Referral_____ VMH ID #_____
Youth's Name_____ Date of Birth _____
Age_____ Ethnicity _____ Gender_____

Under 18 Years of Age
Parent/Legal Guardian_____ County_____
Address_____ City_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Referring Agency_____ Referring Person_____
Address of Referring Person_____
Office Phone_____ Cell Phone_____ E-mail_____

Over 18 years of Age
Address _____City_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Referring Agency_____ Referring Person_____
Address of Referring Person_____
Office Phone_____ Cell Phone_____ E-mail_____

Referral Criteria: Status (Circle One): Diagnosis:
SED* Determination Complete yes no _____
(Serious Emotional Disorder)
*Assessment (please attach most recent)

Transitional Needs:
- ☐ Independent Living Classes
- ☐ Case Management (Level of intensity)_____
- ☐ Medication Management
- ☐ Clinical Services
- ☐ Housing
- ☐ Employment/Education assistance

Services Summary: *Indicate below agencies currently providing services to the youth (Check all that apply)*

Mental Health	Education	DCFS	Juvenile Court	List other agencies and services that apply:
_State Hospital	_Special Education	_Foster Care	__Probation	_____
_Outpatient Treatment	__Title I	__Adoptions	__Parole	_____
_Day Treatment	__YIC	__Family Pres	__Drug Court	_____
_Residential	__Counseling	__CPS	__Truancy Court	_____
_Therapeutic Foster	__Truancy	__Independent Living		
_Medication	__Other_____	__Other_____	__Other_____	
Other_____				

Health	Youth Corrections	DSPD	Substance Abuse
__Special Health Services	__Probation	__Group Care	__Prevention
__Medicaid	__Parole	__Case Management	__Treatment
__Other_____	__Case Management	__ Other_____	__Other_____
_____	__Other_____	_____	_____
_____	_____	_____	_____

Reason for Referral to Project RECONNECT:

What outcomes are being sought for this youth:

Disposition of Case: *(Office use only)*

Case accepted: ___Yes ___No If yes, start date _____

Case Manager assignment: _____

Services being provided:

- ☐ Independent Living Classes
- ☐ Case Management (Level of intensity)_____
- ☐ Medication Management
- ☐ Clinical Services
- ☐ Housing
- ☐ Employment/Education assistance

Approving Signature:_____ Date:_____

Additional Comments:

* *Referrals made from within Valley Mental Health System must be accompanied by a Continuity of Care Form*
* *SED Definition: Serious Emotional Disorder (SED) is the inclusive term for children and adolescents whose emotional and mental disturbance severely limits their development and welfare over a significant period of time and requires a comprehensive coordinated system of care to meet their needs.*

Appendix 9

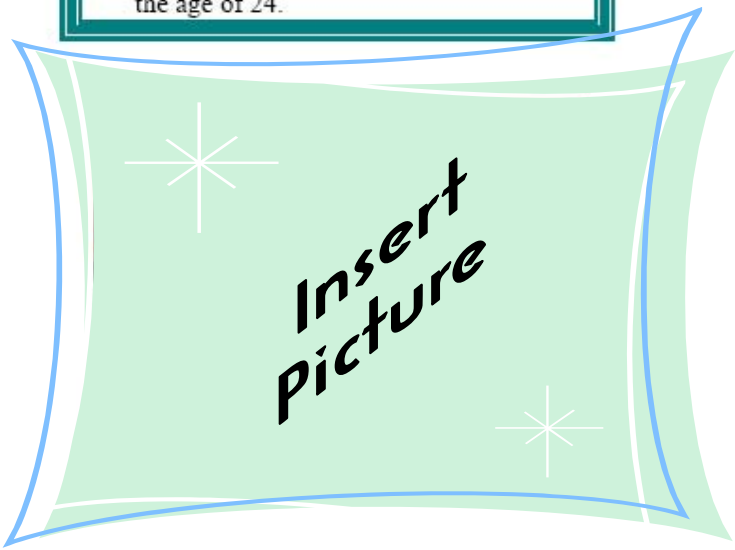
Pamphlet

The Year 18 Myth

The year 18 myth is the commonly held belief that when individuals reach their 18th birthday, not only are they fully matured adults, but they are also fully capable of living on their own.

Fact:

- Only 5-10% of 18-year-olds live on their own in America.
- Human Beings reach full biological and psychological development between the ages of 23 and 25 years.
- Most Americans live on their own after the age of 24.



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Utah Partnership for Youth Transition

PROJECT RECONNECT

Department of Human Services
Division of Substance Abuse and Mental Health

Partnerships for Youth Transition

Project RECONNECT is part of a federally funded project to assist young people to successfully transition to adulthood and to achieve full potential in life. Young people who have emotional or behavioral concerns in childhood and young adults with mental illness may participate in the project.

Only youth between the ages of 14-21 may be admitted to Project RECONNECT, however, once admitted they may continue in the program through age 25.

This project targets the counties of Weber, Morgan, Davis, Summit, Salt Lake, Tooele, Wasatch and Utah. The program is implemented in four community mental health centers: Davis Behavioral Health, Valley Mental Health, Wasatch Mental Health and Weber Human Services.

Mission

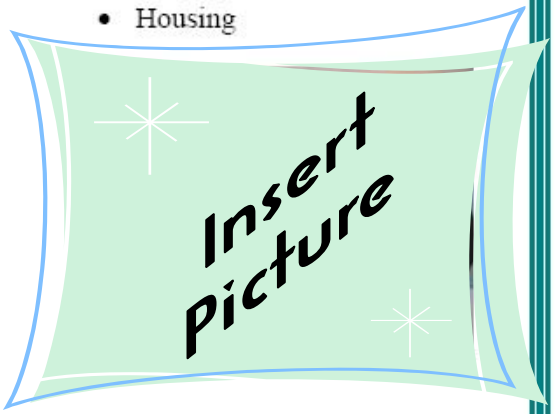
Youth and Young Adults with mental health concerns face additional challenges in transitioning to adulthood. With respect and dignity, these youth, young adults, their families and communities will develop, coordinate and mobilize resources to support and strengthen them in their quest for independence.

Philosophy

Our intention is to honor the full potential and well-being of the target population as they transition into a state of independence. This will be accomplished through services that are youth and family directed, individualized, strength-based and culturally competent, while reducing risk factors and fostering resiliency.

Through connections with competent and caring adults, transitioning youth and young adults will have the resources and support to succeed in all the important areas of their lives:

- Cultural Identity Formation
- Personal Identity Formation
- Supportive Relationships
- Community Connections
- Physical and Mental Health
- Life Skills Acquisition
- Education
- Employment
- Housing



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Appendix 10

Screening Guide

VALLEY MENTAL HEALTH CHILDREN'S OUTPATIENT
CLINICAL SCREENING GUIDE

Client name:_____**Screening #**_____**Age**_____**Gender**_____
Caller's name:_____**Date of appt:**_____

Presenting problem:_____
_____

Any concerns about suicide/self harm?_____
_____

Concerns about threats to others?_____
_____

Alcohol or drug issues?_____
_____

Sex abuse/perpetration/reactivity:_____
_____

Has child been exposed to DV or other trauma?_____
_____

Goals for services:_____
_____

History of MH Tx:_____
Past or current MH meds:_____
Client currently receiving mental health services elsewhere?_____

Other family members in tx at VMH?_____

Adoption issues?_____
_____

Who referred client?_____

Any pending court action? (Divorce, criminal, DCFS)_____
_____

Any custody or visitation issues\ disputes?_____
_____

School functioning:_____
_____

Other:_____
_____

Priority:

- ☐ Emergency (treat as crisis)
- ☐ Urgent (appt within 5 days)
- ☐ Non-urgent (appt within 15 days)
- ☐ Confirm appt. date and time

Give crisis number: 261-1442

USE THIS FORM AS A TEMPLATE FOR SCREENING NOTE

Appendix 11

Transitional Assessment

Historical Transition Assessment of Young Person

Utah

The Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.
Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

Section A. **Author Note: This set of instruments was developed for use by the Partnerships for Youth Transition grant program (Guidance fo Applicants No. SM-02-003), which is jointly funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Special Education Programs, U.S. Department of Education. Development of the instruments was led by the National Technical Assistance Center on Youth Transition (NTAC-YT), which is funded through a grant from the Jim Casey Youth Opportunities Initiative and Annie E. Casey Foundation, with input from the Partnerships for Youth Transition site and national partners.**
A description of the status of the development of these assessment instruments and guidelines for their use are provided in the following manual: Davis, M., Deschenes, N., Gamache, P., and Clark, H. (2004). Transition to Adulthood Assessment Protocol (TAAP): Administration Manual. Tampa: University of South Florida, Florida Mental Health Institute.
For additional information, comments, or questions, please contact Nicole Deschenes, Department of Child and Family Studies, Louis de la parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Down Blvd., MHC 2328, Tampa, FL 33612-3807 Phone: (813)974-4493, Fax: (813)974-6257.
Related Web sites: National Technical Assistance Center on Youth Transition (NYAC-YT) http://ntacyt.fmhi.usf.edu/
Transition to Independence Process (TIP) system http://tip.fmhi.usf.edu/

Section B. **Interview Details**

B-1. Date assessment is begun:

__/__/____

B-2. Date assessment is completed:

__/__/____

B-3. If one or more attempts to contact the young person have been made, please complete the following: Date of attempt #1 to contact young person. If you were successful on the first attempt, skip to B-1.

__/__/____

B-4. Unable to be contacted for interview (check one for each unsuccessful attempt)
Attempt #1:

- O Can't find/contact
- O Refused interview
- O Incarcerated or hospitalized
- O Other (describe)

If other, please describe:

B-5. Date of Attempt #2:

__/__/____

Historical Transition Assessment of Young Person

Utah

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Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

B-6. Unable to be contacted for interview Attempt #2 (check one)

- O Can't find/contact
- O Refused interview
- O Incarcerated or hospitalized
- O Other (describe)

If other, please describe:

B-7. Date of Attempt #3:

__/__/____

B-8. Unable to be contacted for interview Attempt #3 (check one)

- O Can't find/contact
- O Refused interview
- O Incarcerated or hospitalized
- O Other (describe)

If other, please describe:

B-9. Date of Attempt #4:

__/__/____

B-10. Unable to be contacted for interview Attempt #4 (check one)

- O Can't find/contact
- O Refused interview
- O Incarcerated or hospitalized
- O Other (describe)

If other, please describe:

Section C. Young Person Details

C-1. I.D. Code:

C-2. Date of birth:

__/__/____

C-3. Date of service entry:

__/__/____

C-4. Primary language:

Historical Transition Assessment of Young Person

Utah

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Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

C-5. Gender:

- ○ Male
- ○ Female
- ○ Transgender
- ○ Other (specify)

If other, please specify:

C-6. Hispanic or Latino?

- ○ Yes
- ○ No

C-7. If they answered Yes to the above question, what ethnic group does the youth or young adult consider him/her self?

- ○ Central American
- ○ Puerto Rican
- ○ Cuban
- ○ South American
- ○ Dominican
- ○ Mexican
- ○ Other (specify)

If other, please specify:

C-8. Race

- ○ Black or African American
- ○ Alaska Native
- ○ Asian
- ○ White
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian
- ○ Other (specify)

If other, please specify:

Section D. Social History

D-1. Married or living with a long term life partner (Check all that apply)?

- ☐ No
- ☐ Married
- ☐ Divorced/separated
- ☐ Live with significant other

D-2. Number of children (if none, skip to D-4):

Ages of children:

Historical Transition Assessment of Young Person

Utah

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Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

D-3. With whom do children reside? (Check all that apply):

- ☐ Yourself
- ☐ Adoptive parents
- ☐ Child's other parent
- ☐ Foster family
- ☐ Child's extended family
- ☐ In state custody (custody of foster care or juvenile justice systems)
- ☐ Don't know
- ☐ Other (describe)

If other, please describe:

D-4. Family of youth's upbringing. (Suggested wording if interviewing: We would like to understand the role of family in your upbringing. Families come in many different forms, and who is part of your family can change over time, like when your parents remarry, or if you have become part of a foster family. Who are all the people that you think of as having been part of your family during your upbringing?) Check all that apply:

- ☐ Biological mother
- ☐ Stepfather
- ☐ Foster mother
- ☐ Adoptive sibling(s)
- ☐ Grandparent(s)
- ☐ Foster grandparent(s)
- ☐ Other (if there is no identifiable family entity, describe)
- ☐ Biological father
- ☐ Adoptive mother
- ☐ Foster father
- ☐ Step sibling(s)
- ☐ Adoptive grandparent(s)
- ☐ Aunt/Uncle
- ☐ Stepmother
- ☐ Adoptive father
- ☐ Biological sibling(s)
- ☐ Foster sibling(s)
- ☐ Step grandparent(s)
- ☐ Cousins

If other, please describe:

D-5. Past social events before past 90 days (Check all that apply):

- ☐ Married/engaged/made life commitment/moved in together
- ☐ Child given up for adoption/removed from care/parents rights terminated
- ☐ Permanent loss of a sibling (e.g. by death, placement)
- ☐ Serious conflict with someone close (e.g. parent, friend, partner)
- ☐ Divorced/separated/moved out from housing or significant other
- ☐ Adopted child
- ☐ Death of someone close (including parent or sibling)
- ☐ None
- ☐ Gave birth/became a father
- ☐ Permanent loss of a parent (e.g. by death, termination of parental rights (TPR))
- ☐ Loss of relationship with someone close (not above; e.g. best friend moved away)

Section E. Education History

Historical Transition Assessment of Young Person

Utah

The Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.
Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

E-1. Type of schools enrolled in since age 14? (Check all that apply)

- ☐ Regular high school
- ☐ Regular vocational/technical school
- ☐ Residential school
- ☐ Non residential alternative, special education school or center
- ☐ Magnet/Charter school (what type?)
- ☐ Community or 4-year college
- ☐ Vocational/technical training (post high school)
- ☐ Don't know
- ☐ Other (describe)
- ☐ None

If Magnet/Charter school or other, please describe:

E-2. Ever been a Special Education Student with an Individualized Education Program (IEP)?

- ○ Yes
- ○ No
- ○ Don't know

Section F. Employment History

F-1. Type of work held in the past, before the past 90 days (Check all that apply):

- ☐ Don't know (if never skip to G-1)
- ☐ None (if never, skip to G-1)
- ☐ Competitive employment without formal vocational support services
- ☐ Competitive employment with formal vocational support services
- ☐ Supported employment in a protected environment (e.g. job coach; mental health or vocational agency)
- ☐ Transitional employment
- ☐ Sheltered workshop
- ☐ Paid work training experience (e.g. internship, apprenticeship)
- ☐ Informal employment (e.g. illegal, "under the table," odd jobs)

F-2. Age when held first paid job?

F-3. On a scale of 1 to 5, with 1 being the whole time since then and 5 being not at all since then, how much of the time since the start of the first paid job has youth been employed? (Check the answer that best fits)

- ○ 1--The whole time since then
- ○ 2--Most of the time since then
- ○ 3--Sometimes since then
- ○ 4--Hardly ever since then
- ○ 5--Not at all since then
- ○ 99--Don't know

Section G. Legal History

Historical Transition Assessment of Young Person

Utah

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Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

G-1. Documented legal activity in the past, before past 90 days (Check all that apply)

- ☐ Obtained driver's license
- ☐ Registered to vote for first time
- ☐ Arrested, felony charge
- ☐ Arrested, misdemeanor charge
- ☐ Arrested, nuisance/ status/petty charge
- ☐ Arrested, seriousness of charge unknown
- ☐ Convicted of a physically violent crime
- ☐ Put on probation/parole/ other community control
- ☐ Incarcerated
- ☐ Victim of property crime
- ☐ Was physically abused
- ☐ Was criminally neglected
- ☐ Was sexually abused/ assaulted as a child (<18 years)
- ☐ Was sexually abused/ assaulted as an adult (> or = 18 years)
- ☐ Victim of violent crime (not above)
- ☐ No documented legal activity
- ☐ Don't know

G-2. Age when first arrested?

G-3. Arrested since turning 18?

○ Yes ○ No

Section H. Residential History

H-1. Ever lived independently? (if interviewing, suggested wording: Have you ever lived on your own? By on your own we mean without parental supervision, without aunts/uncles/grandparents, and not with others in a program, like a group home or residential program, detention/jail. Living on your own includes living with roommates, with romantic partners, or alone, in a home, dorm or apartment type of setting. It does not include being homeless on your own.) If answer is No, skip to H-6.

○ Yes ○ No

H-2. How old were you when you first lived on your own?

If unknown, please type don't know:

H-3. On a scale of 1 to 5, with 1 being the whole time since then and 5 being not at all since then, how much of the time have you been living on your own since you first moved out on your own? (Check the answer that best fits):

- ○ 1--The whole time since then
- ○ 2--Most of the time since then
- ○ 3--Sometimes since then
- ○ 4--Hardly ever since then
- ○ 5--Not at all since then
- ○ 99--Don't know

H-4. Currently living on own? (if no, skip to H-6)

○ Yes ○ No

Historical Transition Assessment of Young Person

Utah

The Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.

Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

H-5. If living on own, where are you living?

- O With friends (single or multiple friends as rommates--shared household responsibilities)
- O With non-friend roommates
- O At a friend's home or apartment (temporary resident at friends' place)
- O Alone in private residence (rented or owned)

H-6. Have you ever been homeless? (if no, skip to H-10)

- O Yes
- O No

H-7. If you have been homeless, where did you stay? (Check all that apply)

- ☐ Staying at different friends' places
- ☐ Staying at a shelter
- ☐ Living on the streets or in a car
- ☐ Other (describe)

If other, please describe:

H-8. How old were you when you first became homeless?

H-9. On a scale of 1 to 5, with 1 being the whole time since then and 5 being not at all since then, how much of the time have you been homeless since the first time you were homeless? (Check the answer that best fits):

- O 1--The whole time since then
- O 2--Most of the time since then
- O 3--Sometimes since then
- O 4--Hardly ever since then
- O 5--Not at all since then
- O 99--Don't know

H-10. Ever been psychiatrically hospitalized (not ER)? (If no, skip to H-13)

- O Yes
- O No

H-11. Age at first psychiatric hospitalization?

H-12. # of psychiatric hospitalizations:

H-13. Ever in psychiatric residential treatment program? (If no, skip to H-16)

- O Yes
- O No

H-14. Age of first residential treatment program admission?

H-15. # of times in a psychiatric residential treatment program:

Historical Transition Assessment of Young Person

Utah

: Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.

Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

H-16. Ever been hospitalized for substance abuse (not ER)? (If no, skip to H-19)

O Yes O No

H-17. Age at first substance abuse hospitalization?

H-18. # of hospitalizations for substance abuse:

H-19. Ever in a substance abuse residential treatment program? (If no, skip to I-1)

O Yes O No

H-20. Age of first residential treatment program admission?

H-21. # of times in a substance abuse residential treatment program:

S tion I. Mental Health History

I-1. Age when mental health condition started? (suggested wording for interview format: How old were you when you began having difficulties or were first told you had a mental health condition?)

If unknown, please type don't know:

I-2. Age when help first obtained for mental health condition? (suggested wording for interview format: How old were you when help for your condition was first obtained?)

If unknown, please type don't know:

I-3. What was your mental health condition like when you were first having difficulties? (from the youth's perspective)

Historical Transition Assessment of Young Person

Utah

e Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.
Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

Section J. Substance Abuse/Dependence History

J-1. Alcohol or drug abuse/dependence? (suggested wording for interview format: Have you ever had an alcohol or drug use problem?) (Self-identified as interfering with life) If no, skip to K-1

○ Yes ○ No

J-2. Age when this began?

If unknown, please type don't know:

J-3. Age when help first obtained: (suggested wording for interview format: How old were you when you first got help for drug or alcohol use problems - this includes counseling, AA/NA, rehab and the like?)

If unknown, please type don't know:

J-4. What were the alcohol or drug use problems that developed? (from the youth's perspective)

Section K. Mental Health History

K-1. Medical Health Events before past 90 days (Check all that apply):

☐ Traumatic brain injury ☐ Life-threatening or chronic health condition ☐ Serious medical health condition gone into remission/cured

☐ Pregnancy ☐ None ☐ Don't know

Section L. Public Agency Involvement History

For each state/public agency, check Yes, No or Don't know for involvement BEFORE THE PAST 90 DAYS. Indicate the age when that involvement first began for each agency.

L . Child Welfare (child protective or foster care services)

○ Yes ○ No ○ Don't know

Historical Transition Assessment of Young Person

Utah

Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.

Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

L-2. Age at first involvement:

L-3. Juvenile Justice (e.g. detention, community monitoring)

O Yes O No O Don't know

L-4. Age at first involvement:

L-5. Special Education (IEP or 504 plan)

O Yes O No O Don't know

L-6. Age at first involvement:

L-7. Public Mental Health services

O Yes O No O Don't know

L-8. Age at first involvement:

L-9. Developmental Disabilities Services

O Yes O No O Don't know

L-10. Age at first involvement:

L-11. Public Vocational Rehabilitation Services

O Yes O No O Don't know

L-12. Age at first involvement:

L-13. Adult Corrections (adult court, probation, jail/prison, probation)

O Yes O No O Don't know

L-14. Age at first involvement:

L-15. Public Substance Abuse Services

O Yes O No O Don't know

L-16. Age at first involvement:

L-17. Public Assistance

O Yes O No O Don't know

Historical Transition Assessment of Young Person

Utah

Historical Transition Assessment (HTA) is to establish a baseline of information regarding the young person and his/her family and their life circumstances. As a baseline, this Assessent captures lifetime events. An Initial Transition Assessment (ITA) will be conducted at the same time as the HTA.
Note: This HTA should be filled in from whatever sources of information are available (e.g., intake, other school or agency records, youth and/or caregiver interviews).

L-18. Age at first involvement:

L-19. Other (describe)

O Yes O No O Don't know

Please describe:

L-20. Age at first involvement:

Initial Transition Assessment of Young Person - V2

Utah

The Initial Transition Assessment is to establish a base line of information regarding the young person and his/her family and their life circumstances. As a baseline, this assessment captures lifetime events up to 3 months prior to entry to the Partnerships for Youth Transition (PYT) site program. A Quarterly Transition Assessment will be conducted 3 months after the ITA.

Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

Section A. Interview Details

A-1. Date the Assessment is begun

__/__/____

A-2. Date Assessment is Completed

__/__/____

Please describe any challenges you faced in completing this Assessment:

A-3. If one or more attempts to contact the young person have been made, please complete the following: Date of attempt #1 to contact young person. If you were successful on the first attempt, skip to B-1.

__/__/____

A-4. Unable to be contacted for interview (check one for each unsuccessful attempt)
Attempt 1:

- O Can't find/contact
- O Refused Interview
- O Incarcerated or Hospitalized
- O Other (Describe)

If other, please describe

A-5. Date of Attempt #2:

__/__/____

A-6. Unable to be contacted for interview Attempt #2 (check one)

- O Can't find/contact
- O Refuses interview
- O Incarcerated or hospitalized
- O Other (Describe)

If other, please describe

A-7. Date of attempt #3

__/__/____

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

A-8. Unable to be contacted for interview Attempt #3 (check one)

- O Can't find/contact
- O Refuses interview
- O Incarcerated or hospitalized
- O Other (Describe)

If other, please describe

A-9. Date of Attempt #4

__/__/____

A-10. Unable to be contacted for interview Attempt #4 (check one)

- O Can't find/contact
- O Refuses interview
- O Incarcerated or hospitalized
- O Other (Describe)

If other, please describe

Section B. Young Person Details

B-1. ID Code

B-2. Date of Service Entry

__/__/____

Section C. Custody Status of Young Person

C-1. Current Custody Status (check only one)

- O Independent adult (18 or over, no guardian)
- O Adult (18 or over) with guardian
- O Emancipated minor (under 18, declared by the state to be independent)
- O Minor in parental custody
- O Minor in child welfare custody
- O Minor in juvenile justice custody
- O Minor in extended family custody
- O Don't know
- O Other (Describe)

If other, describe

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

C-2. Current Legal Guardian (check only one)

- ○ Self
- ○ Foster Family
- ○ Juvenile Justice
- ○ Parent(s)
- ○ Court-appointed Guardian
- ○ Mental Health
- ○ Extended Family
- ○ Child Welfare
- ○ Don't know

Section D. Social Status

D-1. Person/persons youth spent time with (e.g., on the phone, internet, or in-person) over the past 30 days. [Check all that apply]:

- ☐ Good friend
- ☐ In social group activities (e.g. clubs, sports, malls, church)
- ☐ No one
- ☐ Partner/Spouse
- ☐ Extended family or family of upbringing (i.e. parents, siblings)
- ☐ Don't Know
- ☐ Mentor
- ☐ Spent most non-working/schooling/parenting time alone
- ☐ Other (Describe)

If other, describe

D-2. Social Events in the last 90 days or since the last interview (Check all that apply):

- ☐ Married/engaged/made life commitment/moved in together
- ☐ Child given up for adoption/removed from care/parents rights terminated
- ☐ Permanent loss of a sibling (e.g. by death, placement)
- ☐ Serious conflict with someone close (e.g. parent, friend, partner)
- ☐ Divorced/separated/moved out from housing or significant other
- ☐ Adopted child
- ☐ Death of someone close (including parent or sibling)
- ☐ None
- ☐ Gave birth/became a father
- ☐ Permanent loss of a parent (e.g. by death, termination of parental rights)
- ☐ Loss of relationship with someone close (not above; e.g. best friend moved away)

Section E. Education Status

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

E-1. Indicate current educational status and complete the required comments section for the appropriate selection (check only one):

Enrolled

- O Enrolled in High School/vocational technical high school
- O Enrolled in a GED program
- O Enrolled in 2-year college/community college
- O Enrolled in post-secondary vocational/technical schooling
- O Enrolled in 4-year college
- O Other (describe)

If you selected the first option, please indicate grade level or, if no grade level that the school is non-graded

E-2. Not Enrolled:

- O Permanently dropped out of high school/vo-tech
- O Suspended
- O Expelled from High School
- O Graduated High School
- O High School: Certificate of Completion
- O GED
- O Completed some post secondary schooling (indicate years completed below)
- O Graduated post secondary schooling (indicate 2yr, 4yr, or vo-tech school below)
- O Other (Describe)
- O Educational Status unknown

Please provide detail where requested:

Section F. Employment History and Status

F-1. Currently Employed?

- O Yes
- O No (Skip to F-3)
- O Don't know

F-2. Type of current employment:

- O Part Time (<31 hrs/week)
- O Full time (> or = 31 hrs/week)
- O Don't know

F-3. Type of work held in last 90 days or since last interview (Check all that apply)

- ☐ Don't know (skip to F-7)
- ☐ None (skip to F-7)
- ☐ Competitive employment without formal vocational support services
- ☐ Competitive employment with formal vocational support services
- ☐ Supported employment in protected environment
- ☐ Transitional Employment
- ☐ Sheltered workshop
- ☐ Paid work training experience (e.g. internship, apprenticeship)
- ☐ Informal employment (e.g. illegal, under the table, odd jobs)

Initial Transition Assessment of Young Person - V2

Utah

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F-4. Type of job held within last 90 days or since last interview (check only one)

- ○ Clerical
- ○ Food Services
- ○ Construction / Manual Labor
- ○ Security
- ○ Technical
- ○ Don't know
- ○ Custodial
- ○ Retail
- ○ Other (Specify)

If other, specify:

F-5. Work events in last 90 days or since the last interview (check all that apply)

- ☐ Obtained new job or new employer
- ☐ Demoted
- ☐ Officially reprimanded
- ☐ Other (Describe)
- ☐ Promoted or received wage increase
- ☐ Fired or laid off
- ☐ None
- ☐ Officially praised (e.g. employee of the month)
- ☐ Left job voluntarily
- ☐ Don't know

If other, describe:

F-6. Benefits provided by employer in last 90 days or since the last interview (check all that apply)

- ☐ Health insurance
- ☐ None
- ☐ Paid sick days
- ☐ Don't know
- ☐ Paid vacation leave days
- ☐ Other (Specify)

If other, specify:

F-7. Other activities in last 90 days or since the last interview (check all that apply)

- ☐ Unpaid practicum work experience
- ☐ None
- ☐ Volunteer Work
- ☐ Don't know
- ☐ Parenting of own children
- ☐ Other (Describe)

If other, describe:

Section G. Financial Self-Sufficiency

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

G-1. Sources of income in last 90 days or since the last interview (check all that apply)

- ☐ Work/job
- ☐ Unemployment Benefits
- ☐ Welfare (e.g. TANF, GA, Foodstamps)
- ☐ None
- ☐ Caregivers/family members
- ☐ Disability (SSDI)
- ☐ Housing Assistance (e.g. Section8)
- ☐ Other (Describe)
- ☐ Partner/spouse
- ☐ Non Disability (SSI)
- ☐ Don't know

If other, describe

G-2. If gross income over the past 30 DAYS is known, please indicate:

$

If gross income is not known, please put Unknown below:

Section H. Legal Status

H-1. Documented Legal Activity in last 90 days or since last interview (check all that apply)

- ☐ Obtained driver's license
- ☐ Arrested, misdemeanor charge
- ☐ Convicted of a physically violent crime
- ☐ Victim of property crime
- ☐ Was Sexually abused/assaulted as a child (<18 years)
- ☐ No documented legal activity
- ☐ Registered to vote for the first time
- ☐ Arrested, nuisance/status/petty charge
- ☐ Put on probation/parole/other community control
- ☐ Was physically abused
- ☐ Was sexually abused/assaulted as an adult (18 years or older)
- ☐ Don't know
- ☐ Arrested, felony charge
- ☐ Arrested, seriousness of charge unknown
- ☐ Incarcerated (if since last interview, Indicate # of days incarcerated below)
- ☐ Was criminally neglected
- ☐ Victim of violent crime (not above)

If you selected incarcerated above, please indicate number of days incarcerated below.

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

H-2. Number of arrests for all charges (If 0, skip to I-1)

If unknown, please indicate below:

H-3. Number of incarcerations

If unknown, please indicate below:

Section I. Residential Status

I Residences: Please check only one CURRENT RESIDENCE

- O With family involved in young person's upbrining
- O With own family (spouse,partner,children)
- O With Extended Family
- O With Friends - shared household
- O At friend's home or apt. - temporary
- O With Roommates - not friends
- O Alone in private residence - rented or owned
- O Non-treatment group home (foster care)
- O Psychiatric Hospital
- O Substance Abuse Treatment
- O Residential Psychiatric treatment
- O Substance Abuse Residential Treatment
- O Supervised Housing
- O Corrections Setting
- O Homeless - staying with different friends
- O Homeless - at a shelter
- O Homeless - On the street or car
- O Foster Care - treatment
- O Regular Foster Care
- O Don't Know
- O Other (describe)

If Other, describe:

Initial Transition Assessment of Young Person - V2

Utah

The Initial Transition Assessment is to establish a base line of information regarding the young person and his/her family and their life circumstances. As a baseline, this assessment captures lifetime events up to 3 months prior to entry to the Partnerships for Youth Transition (PYT) site program. A Quarterly Transition Assessment will be conducted 3 months after the ITA.

Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

I-2. Residences: check all other residences in last 90 days or since last interview

- ☐ With family involved in young person's upbringing
- ☐ With one's own family
- ☐ With extended family
- ☐ With friends - shared household
- ☐ At a friends home or apartment
- ☐ With roommates - not friends
- ☐ Alone in a private residence - rented or owned
- ☐ Non-treatment group home
- ☐ Psychiatric Hospital
- ☐ Substance Abuse Hospital Treatment
- ☐ Residential Psychiatric treatment
- ☐ Substance abuse residential treatment
- ☐ Supervised housing
- ☐ Corrections Setting
- ☐ Homeless - Staying with different friends
- ☐ Homeless - at a shelter
- ☐ Homeless - on the street or car
- ☐ Foster Care - Treatment
- ☐ Regular Foster Care
- ☐ Don't know
- ☐ Other (Describe)

If other, describe:

I-3. Residence events in last 90 days or since last interview (check all that apply)

- ☐ Moved (not due to incarceration or treatment setting)
- ☐ Kicked out of/turned away from home/residence
- ☐ Became Homeless
- ☐ Obtained housing (from homeless state)
- ☐ Evicted or told to leave residence
- ☐ Ran away from home/residence
- ☐ None/no changes
- ☐ Don't know
- ☐ Went into or out of treatment/incarceration/group setting

Describe events/dates of changes:

Section J. Current Daily Living Skills

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

J-1. Skills used over the past 30 days (Check all that apply):

- ☐ Did own laundry most of the time
- ☐ Paid own bills most of the time
- ☐ Cooked for self most of the time
- ☐ Was able to get around the community as necessary (e.g. public transportation, drives, uses bicycle)
- ☐ Did own shopping for essentials most of the time
- ☐ Took medications as perscribed or as instructed on medication container
- ☐ Cleaned your room or apartment
- ☐ Other (describe below)
- ☐ Don't know
- ☐ None

If other, describe

Section K. Mental Health Status

K-1. Current diagnoses (Not obtained from youth/family. Enter all that apply)

K-2. What is your mental health condition like now? (From the youth's perspective)

K-3. In the last 90 days or since the last interview, to what extent have mental health conditions interfered with:
Going to school or working

- ○ 0 - Not at all
- ○ 1 - Some
- ○ 2 - A lot
- ○ 3 - Completely

K-4. In the last 90 days or since the last interview, to what extent have mental health conditions interfered with:
Relationships with family, friends, loved ones

- ○ 0 - Not at all
- ○ 1 - Some
- ○ 2 - A lot
- ○ 3 - Completely

Initial Transition Assessment of Young Person - V2

Utah

The Initial Transition Assessment is to establish a base line of information regarding the young person and his/her family and their life circumstances. As a baseline, this assessment captures lifetime events up to 3 months prior to entry to the Partnerships for Youth Transition (PYT) site program. A Quarterly Transition Assessment will be conducted 3 months after the ITA.

Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

K-5. In the last 90 days or since the last interview, to what extent have mental health conditions interfered with:
Ability to live in home-type setting

- O 0 - Not at all
- O 1 - Some
- O 2 - A lot
- O 3 - completely

K-6. Mental health events in the last 90 days or since the last interview [Check all that apply]:

- ☐ Symptoms subsided noticeably and functioning better in home, school, and community
- ☐ Suicide attempt
- ☐ Symptoms increased noticeably and functioning worse in home, school, and community
- ☐ Change in medication
- ☐ Began new mental health treatment (or involvement with a new therapist)
- ☐ Don't know
- ☐ None
- ☐ Other (Describe

If other, describe

Section L. Substance Abuse/Dependence Status

L-1. Document current alcohol or drug use: Enter all that apply. If none, skip to M-1

L-2. In last 90 days or since the last interview, to what extent has alcohol or drug use interfered with:
Going to school or working

- O 0 - Not at all
- O 1 - Some
- O 2 - A lot
- O 3 - Completely

L-3. In last 90 days or since the last interview, to what extent has alcohol or drug use interfered with:
Relationships with family, friends, loved ones

- O 0 - Not at all
- O 1 - Some
- O 2 - A lot
- O 3 - Completely

L-4. In last 90 days or since the last interview, to what extent has alcohol or drug use interfered with:
Ability to live in home-type setting

- O 0 - Not at all
- O 1 - Some
- O 2 - A lot
- O 3 - Completely

Section M. Medical Health Status

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

M-1. Current Medical Health conditions [Enter all that apply]

M-2. In the last 90 days or since the last interview, to what extent have any medical conditions (e.g., illnesses, accidents, surgeries, physical disabilities) interfered with: Going to school or working

O 0 - Not at all O 1 - Some O 2 - A lot
O 3 - Completely

M-3. In the last 90 days or since the last interview, to what extent have any medical conditions (e.g., illnesses, accidents, surgeries, physical disabilities) interfered with: Relationships with family, friends, loved ones

O 0 - Not at all O 1 - Some O 2 - A lot
O 3 - Completely

M-4. In the last 90 days or since the last interview, to what extent have any medical conditions (e.g., illnesses, accidents, surgeries, physical disabilities) interfered with: Ability to live in home-type setting

O 0 - Not at all O 1 - Some O 2 - A lot
O 3 - Completely

M-5. Medical Health Events in last 90 days or since last interview (check all that apply):

☐ Traumatic brain injury
☐ Life-threatening or chronic health condition
☐ Serious medical health condition gone into remission/cured
☐ Pregnancy
☐ None
☐ Don't know
☐ Other (Describe)

If other, describe:

Section N. Public Agency Involvement in the last 90 days:

For each state/public agency, check Y =yes, N=no, or DK=Don't know. Include the age when that involvement first began for each agency.

N-1. Child Welfare (child protective or foster care services)

O Y O N O DK

N-2. Age at first involvement

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

N-3. Juvenile Justice (e.g., detention, community monitoring)

O Y O N O DK

N-4. Age at first involvement

N-5. Special Education (IEP or 504 plan)

O Y O N O DK

N-6. Age at first involvement

N-7. Public Mental Health services

O Y O N O DK

N-8. Age at first involvement

N-9. Developmental Disabilities Services

O Y O N O DK

N-10. Age at first involvement

N-11. Public Vocational Rehabilitation Services

O Y O N O DK

N-12. Age at first involvement

N-13. Adult Corrections (adult court, probation, jail/prison, probation)

O Y O N O DK

N-14. Age at first involvement

N-15. Public Substance Abuse Services

O Y O N O DK

N-16. Age at first involvement

N-17. Public Assistance

O Y O N O DK

N-18. Age at first involvement

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

N-19. Other (describe):

○ Y ○ N ○ DK

Please Describe:

N-20. Age at first involvement

Section O. Support Services utilization

O-1. Indicate all current health care coverage:
Mental Health Care

☐ Private Insurance ☐ Medicaid ☐ Don't know
☐ Other (Describe) ☐ None

If other, describe

O-2. Substance Abuse Care

☐ Private Insurance ☐ Medicaid ☐ Don't know
☐ Other (Describe) ☐ None

If other, describe

O-3. Medical Health Care

☐ Private Insurance ☐ Medicaid ☐ Don't know
☐ Other (Describe) ☐ None

If other, describe

Section P. Medical, Mental Health and Substance Abuse Services

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

P-1. Received mental health service in last 90 days or since last interview (e.g., visit with psychiatrist, psychotropic medication consult, stress or anger management classes, emergency room visits, counseling, therapy, or guidance with an individual counselor, with others in group counseling, with family or partners for relationship or other problems or any service along those lines.)

O Yes O No (Skip to P-5) O Don't Know

P-2. Describe who provided it, what was it for, what agency, etc. (Should be able to derive the agency providing the care from this information)

P-3. Rate how helpful the overall mental health service system was

O 0 - Not at all O 1 - Some O 2 - A lot
O 3 - Completely O 99 - Don't Know

P-4. Rated by:

O Youth O Transition Specialist O Other (Describe)

If other, describe

P-5. Describe any wanted/needed mental health care that was not received

O N/A O None O Select and describe below

Describe:

P-6. Received counseling, or therapy for drug or alcohol use in last 90 days or since last interview (with an individual counselor, with others in group counseling, at an AA meeting or any service along those lines.)

O Yes O No (Skip to P-10) O Don't know

P-7. Describe who provided it, what was it for, what agency, etc. (Should be able to derive the agency providing the care from this information):

Initial Transition Assessment of Young Person - V2

Utah

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Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

P-8. Rate how helpful the overall substance abuse service system was

- O 0 - Not at all
- O 1 - Some
- O 2 - A lot
- O 3 - Completely
- O 99 - Don't know

P-9. Rated by:

- O Youth
- O Transitional Specialist
- O Other (describe)

If other, describe:

P-10. Describe any wanted/needed substance abuse care that was not received

- O N/A
- O None
- O Yes, described below

Describe

P-11. Received medical care (that is, physical health) in last 90 days or since the last interview (e.g., a doctor's visit, a checkup, physical therapy or any service along those lines.)

- O Yes
- O No (Skip to P-15)
- O Don't know

P-12. Describe who provided it, what was it for, what agency, etc. (Should be able to derive the agency providing the care from this information)

P-13. Rate how helpful the overall medical care service system was:

- O 0 - Not at all
- O 1 - Some
- O 2 - A lot
- O 3 - Completely
- O 99 - Don't know

P-14. Rated by:

- O Youth
- O Transition Specialist
- O Other (Describe)

Describe

Initial Transition Assessment of Young Person - V2

Utah

The Initial Transition Assessment is to establish a base line of information regarding the young person and his/her family and their life circumstances. As a baseline, this assessment captures lifetime events up to 3 months prior to entry to the Partnerships for Youth Transition (PYT) site program. A Quarterly Transition Assessment will be conducted 3 months after the ITA.

Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

P-15. Describe any wanted/needed Medical health care that was not received

O N/A O None O Yes, described below

Describe:

P-16. Indicate any additional services or supports received since the last interview that were not described above (check all that apply starting w/ P-18):

O No additional help reported (skip to P-32) O Don't know (skip to P-32) O None (Skip to P-32)

P-17. For all the following services, indicate who rated the helpfulness of service:

O Youth O Transition Specialist O Other (Describe)

If other, describe

P-18. Using the following scale, respond to items P-18 thru P-31)
0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know
Help with Jobs or career e.g., getting/keeping a job, thinking about desired future job

O 0 O 1 O 2
O 3 O 99 O Not Applicable

P-19. Help with planning for future
0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

O 0 O 1 O 2
O 3 O 99 O Not Applicable

P-20. Help with schooling e.g., staying in school, finding another school, getting GED
0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

O 0 O 1 O 2
O 3 O 99 O Not Applicable

P-21. Help with getting own place to live e.g., finding an apartment, getting roommates
0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

O 0 O 1 O 2
O 3 O 99 O Not Applicable

P-22. Help with learning how to live on his/her own e.g., cooking, laundry, paying bills
0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

O 0 O 1 O 2
O 3 O 99 O Not Applicable

P-23. Help with relationships e.g., communicating well, controlling anger, finding friends or people to talk to and do things with, getting along with family
0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

O 0 O 1 O 2
O 3 O 99 O Not Applicable

Initial Transition Assessment of Young Person - V2

Utah

The Initial Transition Assessment is to establish a base line of information regarding the young person and his/her family and their life circumstances. As a baseline, this assessment captures lifetime events up to 3 months prior to entry to the Partnerships for Youth Transition (PYT) site program. A Quarterly Transition Assessment will be conducted 3 months after the ITA.

Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

P-24. Help with finding or doing fun activities e.g., joining a basketball league, taking art classes

0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

P-25. Help with learning to raise children, or finding child care

0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

P-26. Help with transportation e.g., getting a car, using the bus/subway system

0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

P-27. Help with legal problems

0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

P-28. Help with entitlements or public assistance e.g., getting SSI or Medicaid, or unemployment

0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

P-29. Other (Describe)

0=Not at all; 1=Some; 2=A lot; 3=Completely; 99=Don't know

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

Describe

P-30. Other (Describe)

○ 0 ○ 1 ○ 2
○ 3 ○ 99 ○ Not Applicable

Describe

Initial Transition Assessment of Young Person - V2

Utah

The Initial Transition Assessment is to establish a base line of information regarding the young person and his/her family and their life circumstances. As a baseline, this assessment captures lifetime events up to 3 months prior to entry to the Partnerships for Youth Transition (PYT) site program. A Quarterly Transition Assessment will be conducted 3 months after the ITA.

Note: This ITA should be filled in from whatever sources of information are available (e.g. intake, other school or agency records, youth and/or caregiver interviews).

P-31. Other (Describe)

- O 0
- O 1
- O 2
- O 3
- O 99
- O Not Applicable

Describe

P-32. Is there someone who helps with most of these types of problems (i.e. someone who helps figure out how to solve problems, who helps to think about the future and what is needed to achieve goals)?

- O Yes
- O No (End Assessment)
- O Don't Know (End Assessment)

P-33. Who is that person? (name, where they work (if applicable)

Appendix 12

Fidelity Measures

Project RECONNECT
Department of Human Services
Division of Substance Abuse and Mental Health

Elements	Summative Statement	Almost Never	Infrequently	Sometimes	Frequently	Almost Always
	Administrative Elements					
Eligibility	Young people who are between the ages of 14 and 21 may be admitted into the program, but once admitted, they may continue in the program through age 25.					
	Young people who are diagnosed with serious emotional disturbances (SED) in childhood or with newly emerging serious mental illness (SMI).					
Collaboration w/ Non-MH Providers	There is a mechanism for collaboration with key partners in the areas of employment, living situation, education, community life and other partners such as Indian tribes, state and local public agencies in child welfare, juvenile justice, and disability issue.					
Management	Transitional service is illustrated in the organizational chart.					
	The agency staff, including administrators, supervisors, co-workers (clinicians and case managers), and Transitional Facilitators undergo appropriate training and orientations					
	The roles and functions of administrators, supervisors, co-workers, and Transitional Facilitators are well defined and assigned to appropriate staff so all transition-relevant functions are carried out with fidelity.					
	The mechanism for supervision and consultation ensures professional growth and accountability by Facilitators.					
Facility Design	Facilitators have access to work space, including meeting rooms, that ensures confidentiality.					
	Facilitators have access to adequate technologies and equipments to perform duties at job site and in the field.					
Caseload	The caseload size allows the Facilitator to provide adequate attention and support to young people and that young people receive adequate individualized services. It takes into account the characteristics of cases and the Facilitator's limitations.					
Flexible Funds	Program budget shows flexible funds as dedicated funds for program participants.					
	There is a clear mechanism to approve and disburse flexible funds					
Program Costs	Program cost adheres to the financing guidelines.					
	System Elements					
Intra-Agency Collaboration	There are clear policy and procedure that allow easy and gradual transitioning of young people from children/youth system to the adult system within the agency.					
	There is mechanism for cross training for children/youth and adult systems within the agency.					
	Cross staffing occurs for all transitioning youth cases.					

Community Development	Steering Committee membership is inclusive; it's roles and functions are well defined, including project oversight and community mobilization. The Committee meets regularly.					
	If appropriate, local Advisory Councils and workgroups are organized and meet regularly.					
Family Development	The Family Council's roles and functions are well defined with a strong family focus. The Council meets regularly.					
	Family Council members receive leadership training.					
	Every family member is provided with the opportunity to attend the Family Orientation.					
Youth Development	The Youth Council's roles and functions are well defined with a strong youth focus. The Council meets regularly.					
	Youth Council members receive leadership training.					
Cultural Competence	Cultural Competency Advisory Council membership represents the diversity of the community; it's roles and functions are well defined with a strong cultural competency focus. The Council meets regularly.					
	Staff receives training on the Cultural Competency Practice Model and cultural diversity.					
	Cultural Consultant Resource Bank is organized.					
	Clinical Elements					
Principles of The Practice	The Project adheres to the seven System of Care guiding principles					
Pathway Into Care	The Project has a clear pathway into care diagram that illustrate sequential steps.					
Social Marketing and Outreach	The Project has a clear social marketing and outreach plan to increase the community's knowledge and awareness of the Project.					
Referral	The Project has a mechanism to track the referral sources and responses.					
Screening	The Project has a clear process to screening young people for their appropriateness for the Project.					
Assessment and Treatment Planning	Each young person receives clinical assessment and transitional assessment conducted by appropriately licensed professionals.					
	Transitional assessment and planning is comprehensive, individualized and strength-based.					
Engagement	The Project has a clear method to retain young people and their families' engagement in the Project.					
Transition Facilitation	The Facilitator provides transition facilitation in four domains - education, employment, living situation and community life adjustment – in an orderly and sequential manner.					
	Each young person has a Transitional Team to assist in his/her transitioning process.					
Service Coordination	The Transitional Facilitator provides case management and service coordination across mental health, substance abuse, education, vocational training, employment, housing, health, legal assistance, and instrumental living skills, as well as the adult system					
Family and Peer Support	Developing and maintaining family and peer support are an integral part of the transitional services.					
Crisis and Safety Planning	Every young person has a crisis plan that addresses risk reduction. Young person also will have a safety plan if there is a tangible safety risk to self, home and community.					

Appendix 13

Client Satisfaction Questionnaire

Center Name: _____ **Youth ID:** _____ **Date:** _____

Would you like your therapist to see your answers to this questionnaire? Yes _____
No _____

YOUTH SERVICES SURVEY: YOUTH VERSION

Please help our agency make services better by answering some questions about the services you have received. Your answers will be kept confidential. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statements below. Put a cross (**X**) in the box that best describes your answer. Thank you!

	Strongly Disagree (1)	**Disagree** (2)	**Undecided** (3)	**Agree** (4)	**Strongly Agree** (5)
1. Overall, I am satisfied with the services I received.					
<u>As a result of the services I received:</u>					
2. I am better at handling daily life.					
3. I get along better with family members.					
4. I get along better with friends and other people.					
5. I am doing better in school and/or work.					
6. I am better able to cope when things go wrong.					
7. I am satisfied with my family life right now.					
<u>Feedback about the services I received:</u>					
8. I helped to choose my services.					
9. I helped to choose my treatment goals.					
10. The people helping me stuck with me no matter what.					
11. I felt I had someone to talk to when I was troubled.					
12. The people helping me listened to what I had to say.					
13. I was actively involved in my own treatment.					
14. I received services that were right for me.					
15. The location of services was convenient.					
16. Services were available at times that were convenient for me.					
17. If I need services in the future, I would use these services again.					
18. I got the help I wanted.					
19. I got as much help as I needed.					
20. I, not staff, decided my treatment goals.					
21. Staff treated me with respect.					
22. Staff understood my family's cultural traditions.					
23. Staff respected my family's religious/spiritual beliefs.					
24. Staff spoke with me in a way that I understood.					
25. Staff were sensitive to my cultural/ethnic background.					

Continued on other side

26. What did you LIKE about our services?

27. What did you NOT LIKE about our services?

28. What could we do to IMPROVE our services?

Thank you for taking the time to answer these questions!

Center Name/ID: _____ **Youth ID:** _____ **Date:** _____

YOUTH SERVICES SURVEY – PARENT OR CAREGIVER VERSION

Please help our agency make services better by answering some questions about the services your has child received. Your answers will be kept confidential. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statements below. Put a cross (**X**) in the box that best describes your answer. Thank you!

How are you related to this child? (Check one)

____ Mother Foster mother _____ Other relative _____

____ Father Foster father _____

	Strongly Disagree (1)	**Disagree** (2)	**Undecided** (3)	**Agree** (4)	**Strongly Agree** (5)
1. Overall, I am satisfied with the services my child received.					
<u>As a result of the services my child and/or family received:</u>					
2. My child is better at handling daily life.					
3. My child gets along better with family members.					
4. My child gets along better with friends and other people.					
5. My child is doing better in school and/or work.					
6. My child is better able to cope when things go wrong.					
7. I am satisfied with our family life right now.					
<u>Feedback about the services my child and/or family received:</u>					
8. I helped to choose my child's services.					
9. I helped to choose my child's treatment goals.					
10. The people helping my child stuck with us no matter what.					
11. I felt my child had someone to talk to when he/she was troubled.					
12. The people helping my child listened to what he/she had to say.					
13. I was frequently involved in my child's treatment.					
14. The services my child and/or family received were right for us.					
15. The location of services was convenient for us.					
16. Services were available at times that were convenient for us.					
17. If I need services for my child in the future, I would use these services again.					
18. My family got the help we wanted for my child.					
19. My family got as much help as we needed for my child.					
20. My child *and* family's needs determined my child's treatment goals.					
21. Staff treated me with respect.					
22. Staff understood my family's cultural traditions.					
23. Staff respected my family's religious/spiritual beliefs.					

Continued on other side

	Strongly Disagree (1)	**Disagree** (2)	**Undecided** (3)	**Agree** (4)	**Strongly Agree** (5)
24. Staff spoke with me in a way that I understood.					
25. Staff were sensitive to my cultural/ethnic background.					

29. What did you LIKE about our services?

30. What did you NOT LIKE about our services?

31. What could we do to IMPROVE our services?

Thank you for taking the time to answer these questions!